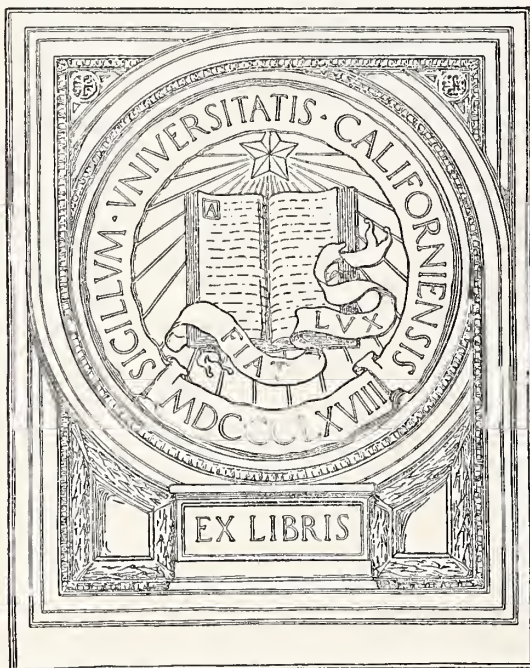
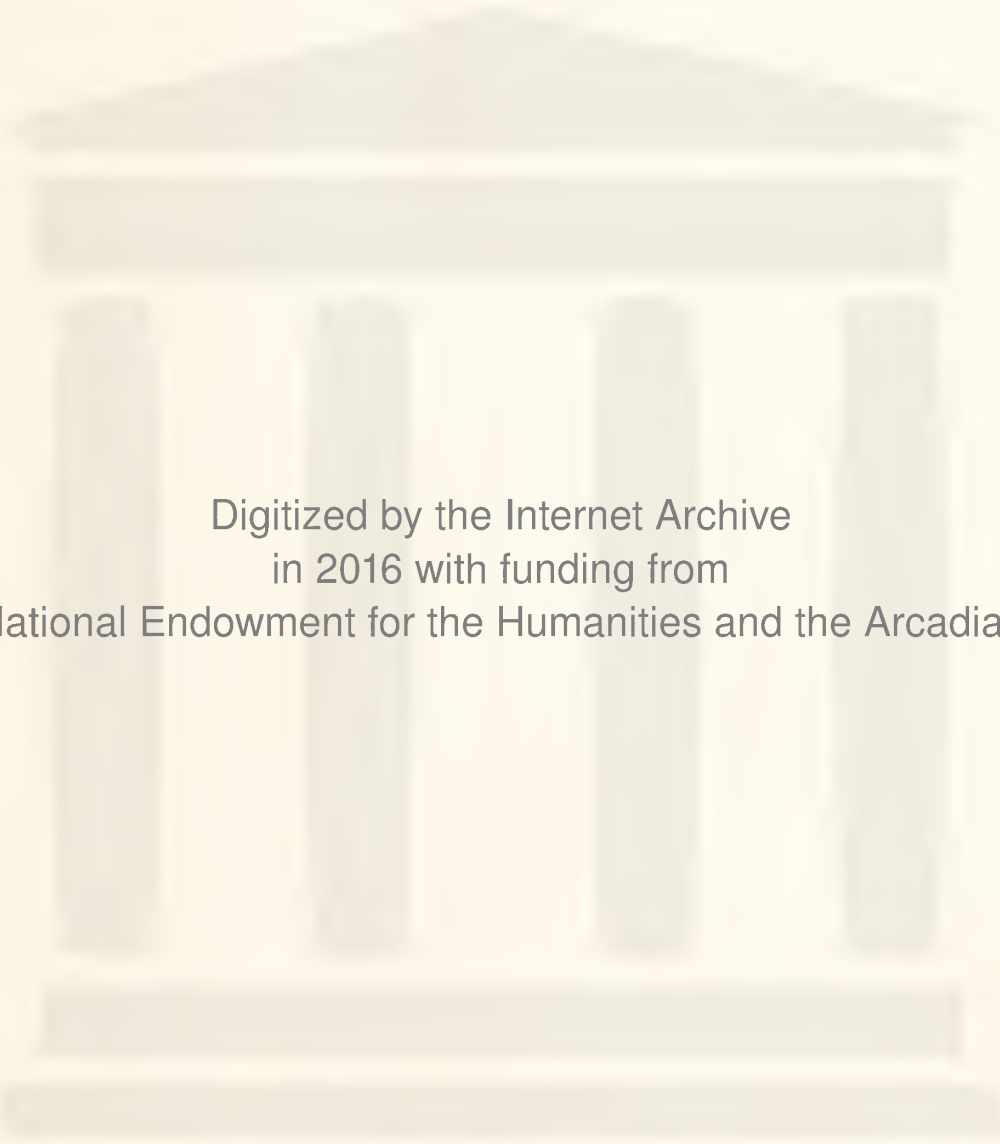


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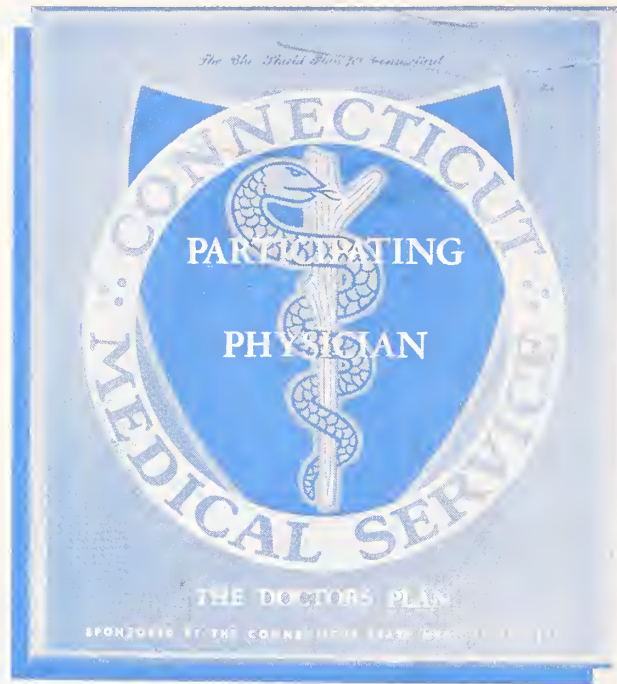
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The CONNECTICUT STATE MEDICAL JOURNAL

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No. 1

PLASTIC SURGERY IN CANCER OF THE FACE

ALFONSO A. DIECIDUE, M.D., *Bridgeport*

CONSIDERING the ease with which a diagnosis of cancer of the face can be made, too frequently these lesions are treated conservatively. When conservative treatment is employed one frequently finds recurrences which may become fixed to bone or cartilage and possibly metastasize to the neck. When this occurs an otherwise simple treatment becomes much more radical and the outlook for controlling the lesion much more pessimistic.

The chances for permanent cure are greatly increased when radical excision of the neoplasm is employed. Permanent cure is even more likely if the surgeon examines the patient before a specimen is removed for biopsy purposes. In this way the surgeon can determine the extent of the tumor and how widely to remove the tumor beyond the apparent margin. Furthermore if the surgeon takes a biopsy specimen he can plan his incision so that it will not interfere with a pedicle flap or a rotation flap which he might employ in his reconstruction of a large defect produced by the excised tumor. This is especially important in those cases where entire removal of the tumor constitutes the biopsy. In other words, the surgical removal of a cancer of the face should be preceded by a carefully thought out plan of approach so that not only complete excision of the lesion is achieved but functional and cosmetic restoration as well.

The surgical management of cancerous lesions of the face can be simple or it may involve complicated reconstructive procedures.

Falling in the category of the more simple treatments are those lesions which can be radically excised and the wounds closed immediately by simple approximation of their edges. As examples there are the small basal cell and the low grade squamous cell carcinomas which are so situated in the

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SUMMARY

Radical surgical excision of lesions of cancer of the face should be employed if permanent cure is to be expected. Simple excision will suffice in some instances, whereas in others plastic procedures may be necessary. Illustrative examples are furnished.



FIGURE 1A

Epidermoid ca. of lower lip

face that primary closure of the wound is possible after radical excision of the growth. (Figure 1.)

However, the types of lesions just mentioned, although small in size, may be so situated in the face that primary closure can not be employed because it would create distortion of facial features. This type of defect must be closed by a skin graft or by a local rotation flap. Figure 2 illustrates a basal cell carcinoma which following excision can not be closed

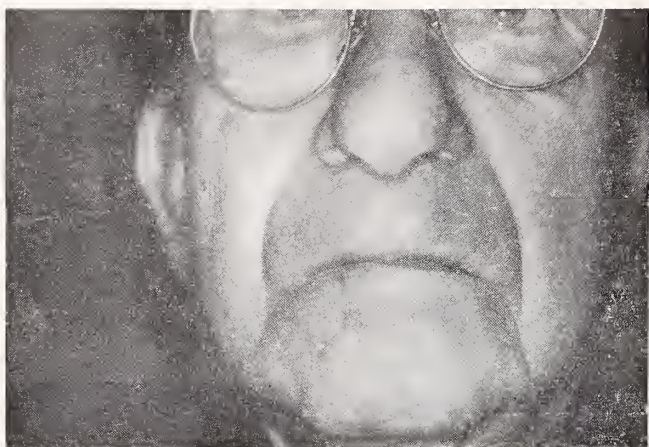


FIGURE 1B
Following radical excision and primary closure

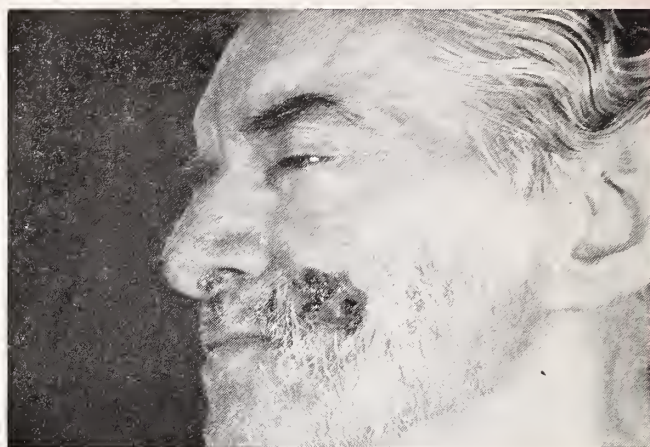


FIGURE 3A
Basal cell ca. face



FIGURE 2A
Basal cell ca.



FIGURE 3B
Following radical excision and repair with large facial rotation flap. Sutures still in place



FIGURE 2B
Following radical excision and repair with full thickness postauricular skin graft



FIGURE 3C
Six months postoperative

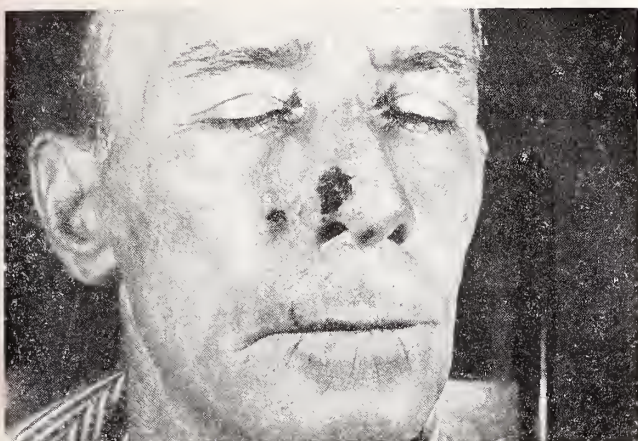


FIGURE 4A
Basal cell ca. nose

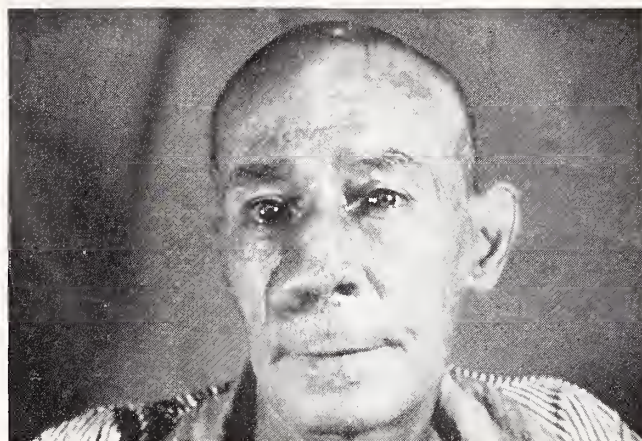


FIGURE 4D
Following nose reconstruction. Pt. will require further stage revision



FIGURE 4B
Following radical excision



FIGURE 5A
Basal cell ca. face involving both lips and oral commissure



FIGURE 4C
Modified sickle cell flap for nose reconstruction



FIGURE 5B
Following radical excision of lesion



FIGURE 5C

One stage reconstructive procedure utilizing a large rotation flap, a nasolabial flap, and an Abbe flap from lower lip

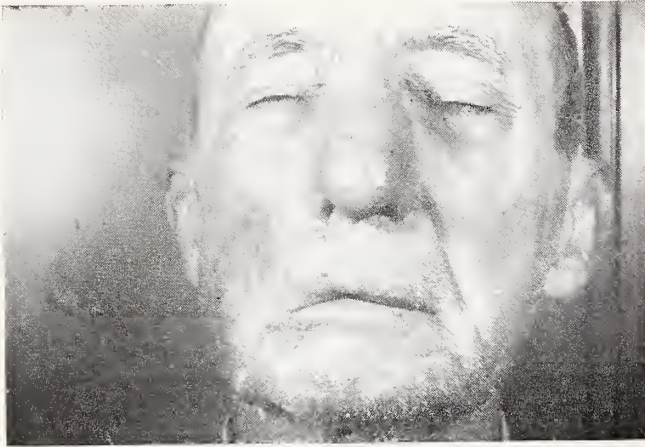


FIGURE 5D

Final result. Six months postoperative

without producing an ectropion of the lower eyelid. There is not sufficient tissue in the adjacent area to utilize a rotation flap so a skin graft must necessarily be employed. Figure 3 illustrates a moderately large basal cell carcinoma which following radical excision can be closed by a local rotation flap.

Then there are those types of lesions which involve vital structures of the face such as the nose, eyelids, mouth, etc. Radical excisions here result in loss of part or entire portions of the involved structures which require reconstructive procedures. Figures 4 and 5 illustrate cases of this nature.

CONCLUSIONS

Considering the ease with which a diagnosis of cancer of the face can be made, the too frequent conservative method of treatment should be abolished in favor of surgical treatment. True, radical excision of some lesions may involve vital structures of the face, thus producing functional and cosmetic deformities. However, modern day reconstructive surgery provides for adequate restoration of these disabilities.

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CHEMICAL CORNEAL BURNS

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IN order to compare the damage done to the rabbit cornea by various chemicals, and also to evaluate the effect of various treatments, a series of experiments were made. In the major group the chemical lesions were confined to the cornea, in a minor group purposely conjunctival lesions were added to the corneal ones.

The lesions were confined to a certain area of the cornea by pressing on the cornea the opening made in a bent glass tube. One end of the tube allows the chemical to be deposited on the cornea by dropper or syringe; the other end is connected with a rubber tube through which water or any neutralizing fluid can be flushed over the exposed area of the cornea.

When additional conjunctival lesions were wanted, the glass tube was removed immediately after application of the chemical on the cornea.

The severity of the damage done to the eye was evaluated by the numerical method of quantitative evaluations of the different disease manifestations.

In each lesion the following items were studied:

I. The intensity of corneal opacity as seen by focal illumination.

II. Intensity of corneal opacity as seen with the slitlamp.

III. Corneal slough and ulceration.

IV. Duration of active signs.

V. Vessels in cornea.

VI. Conjunctiva.

VII. Anterior chamber.

VIII. Microscopic slides.

Ad. I. By focal illumination the corneal opacity was studied. A nebula was given 2 points; a macula, 4; a leucoma, 6; a deformation of the cornea, 8 points.

Ad. II. Slitlamp observation revealed how deep the opacity had penetrated. If only in epithelium and superficial stroma, 2 points were given; for lesions

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SUMMARY

A series of experiments made on the rabbit cornea by various chemicals is described. A comparison is made of the damage done by these different agents. Certain conclusions are reached as a result of these experiments and practical considerations for use in the human eye are noted.

not deeper than medial layers of the cornea, 5 points; throughout corneal stroma, 8; with additional changes in Descemet and endothelium, 10.

Ad. III. Corneal slough and ulceration received the following marks: denuded epithelium—2 points; moderate slough—5 points; pronounced slough—8 points; perforation—12 points.

Ad. IV. If within a week the active signs disappeared, 5 points were added; if this took from 1-2 weeks, 10; if from 2-4 weeks, 15; if over 4 weeks, 20.

Ad. V. For some pericorneal hyperemia 2 points were given; if superficial vessels showed over the minor part of the cornea, 5; if over major part, 8; if the cornea showed deep vessels, 10.

Ad. VI. For redness of the conjunctiva, one point was added; in addition to this, 5 more for chemosis; in addition, 5 more for necrosis and in addition 5 more for pronounced conjunctival discharge.

Ad. VII. The condition of the eye behind the cornea was evaluated as follows: A small pupil, photophobia, 2 points; iris vessels, Tyndall phenomenon, 5 points; exudative iritis, 8 points; panophthalmitis, either following or without previous perforation, 12 points.

Ad. VIII. Microscopic slides were made and

Aided by a Grant from the National Council to Combat Blindness, Inc., New York

		evaluation of different signs	rinsed with water neutralizing solution cortisone hydrosulphosol corvasymptom adrenalone water plus anesthetics							rinsed with water neutralizing solution cortisone hydrosulphosol corvasymptom adrenalone water plus anesthetics							rinsed with water neutralizing solution cortisone hydrosulphosol corvasymptom adrenalone water plus anesthetics						
			weak acids (cornea only)							weak alkalies (cornea only)							medium acids (cornea only)						
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
I. Intensity corneal opacity (focal illumination)			2	2	2	2	2	2	2	—	—	—	—	—	—	—	—	—	—	—	—	—	
nebula			4	—	—	—	—	—	—	4	4	4	4	4	4	4	—	—	2	—	2	—	
macula			6	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
leucoma			8	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
deformation																							
II. Intensity corneal capacity (slit lamp)																							
opacity in epithelium, superf. stroma....			2	2	2	2	2	2	2	—	2	—	—	—	—	—	—	—	2	—	2	—	
opacity not deeper than medial stroma			5	—	—	—	—	—	—	5	—	5	—	5	5	5	5	5	—	5	—		
opacity throughout stroma.....			8	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—		
opacity endothelium, descemet.....			10	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—		
III. Corneal slough and ulceration																							
denuded epithelium			2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	2	—	2	—	
moderate slough			5	—	—	—	—	—	—	5	5	5	5	5	5	5	5	—	5	—	5	5	
pronounced slough			8	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
perforation			12	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
IV. Duration till healing																							
1 week			5	5	5	5	5	5	5	—	—	—	—	—	—	—	—	—	—	—	—	—	
1-2 weeks			10	—	—	—	—	—	—	10	10	10	10	10	10	10	10	10	10	10	10	10	
2-4 weeks			15	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
over 4 weeks.....			20	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
V. Vessels in cornea																							
superficial, limbal			2	2	2	2	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	
superficial, minor half cornea.....			5	—	—	—	—	—	—	5	—	5	5	5	5	5	5	5	5	5	5	5	
superficial, major half cornea.....			8	—	—	—	—	—	—	—	8	—	—	—	—	—	—	—	—	—	—	—	
deep			10	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
VI. Conjunctiva																							
redness			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
chemosis			5	—	—	—	—	—	—	5	5	5	5	5	5	5	5	—	5	—	—	5	
necrosis			5	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
pronounced discharge			5	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
VII. Anterior Chamber																							
small pupil, photophobia.....			2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
iris vessels, Tyndall.....			5	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
exudative iritis			8	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
Panophthalmitis with perforation.....			12	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
panophthalmitis without perforation....			12	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
VIII. Microscopy																							
changes in epithelium.....			2	2	2	2	2	2	2	—	—	2	—	—	—	—	—	—	2	—	2	—	
changes in stroma.....			4	—	—	—	—	—	—	4	4	—	4	4	4	4	4	4	—	—	—	4	
changes in endothelium.....			6	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
cataract			8	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
iritis			8	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
TOTALS				14	14	14	14	12	12	19	39	39	37	34	39	39	39	34	31	26	39	26	

rinsed with water neutralizing solution cortisone hydrosulphosol corvasymptom adrenalone water plus anesthetics								rinsed with water neutralizing solution cortisone hydrosulphosol corvasymptom adrenalone water plus anesthetics								rinsed with water neutralizing solution cortisone hydrosulphosol corvasymptom adrenalone water plus anesthetics								rinsed with water neutralizing solution cortisone hydrosulphosol corvasymptom adrenalone water plus anesthetics								rinsed with water neutralizing solution cortisone hydrosulphosol corvasymptom adrenalone water plus anesthetics							
medium alkalis (cornea only)								strong acids (cornea only)								strong alkalis (cornea only)								medium acids (cornea and conjunctiva)								medium alkalis (cornea and conjunctiva)							
22	23	24	25	26	27	28		29	30	31	32	33	34	35		36	37	38	39	40	41	42		43	44	45	46	47	48	49		50	51	52	53	54	55	56	
—	—	—	—	—	—	—		—	—	—	—	—	—	—		—	—	—	—	—	—	—		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
—	—	—	—	—	4	—		—	—	—	—	—	—	—		—	—	—	—	—	—	—		4	4	4	4	4	4	4	—	—	—	—	—	—	—	—	
6	—	—	—	—	—	—		6	6	6	6	6	6	6		—	—	—	—	—	—	—		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
—	6	6	6	6	—	6	6	—	—	—	—	—	—	—		8	8	8	8	8	8	8		—	—	—	—	—	—	—	—	6	6	6	6	—	6	6	
—	—	—	—	—	—	—		—	—	—	—	—	—	—		—	—	—	—	—	—	—		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
—	5	—	—	—	—	5	5	—	—	—	—	—	—	—		—	—	—	—	—	—	—		5	—	5	—	5	5	—	—	—	5	—	—	5	5	—	
8	—	8	8	8	8	—		8	8	8	8	8	8	8		—	—	—	—	—	—	—		—	8	—	8	—	—	8	—	8	—	8	—	—	—	—	
—	—	—	—	—	—	—		—	—	—	—	—	—	—		—	—	—	—	—	—	—		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
8	5	—	5	—	5	—		5	—	—	—	—	—	—		10	10	10	10	10	10	10		5	5	5	5	5	5	5	—	—	—	—	5	—	—		
—	—	8	—	8	—	8		—	8	8	8	8	8	8		8	8	—	8	—	8	—		—	—	—	—	—	—	—	—	8	8	8	8	8	—	8	
—	—	—	—	—	—	—		—	—	—	—	—	—	—		—	—	12	—	12	12	—		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
—	—	—	—	—	—	—		—	—	—	—	—	—	—		—	—	—	10	10	—	—	10		15	15	15	15	15	10	15	—	15	15	15	15	15	—	
15	—	—	—	—	—	—		15	—	15	—	15	15	—		15	15	—	—	—	15	15		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
—	15	15	15	15	15	15		—	20	—	20	—	—	20		—	—	—	—	—	—	—		—	—	—	—	—	—	—	—	—	—	—	—	—	20		
—	—	—	—	—	—	—		—	—	—	—	—	—	—		—	—	—	—	—	—	—		5	5	5	5	5	5	5	—	—	—	—	—	—	—	—	
8	8	—	8	8	—	—		—	—	—	—	8	—	—		8	8	8	—	—	—	—		—	—	—	—	—	—	—	—	—	8	—	8	—	—		
—	—	10	—	—	10	10		10	10	10	10	—	10	10		—	—	—	10	10	10	10		—	—	—	—	—	—	—	—	10	—	10	—	10	10		
1	1	1	1	1	1	1		1	1	1	1	1	1	1		1	1	1	1	1	1	1		1	1	1	1	1	1	1	1	1	1	1	1	1	1		
5	5	5	5	5	5	5		5	5	5	5	5	—	5		5	5	5	5	5	5	5		—	—	—	5	—	5	—	5	5	5	5	5	5	5		
—	—	—	5	—	—	5		5	5	—	—	—	—	5		—	—	—	—	5	—	5		—	5	5	—	5	—	—	5	—	5	5	5	5	5		
—	—	—	—	—	—	—		—	—	5	—	—	—	—		5	5	5	5	—	—	5		5	5	5	5	—	—	5	—	—	5	5	5	—	5		
—	2	—	—	—	2	2		—	2	2	—	2	—	2		—	—	—	—	—	—	—		—	—	—	—	—	—	—	—	—	—	—	—	—	—		
5	—	5	5	5	—	5		—	—	—	—	—	—	—		—	—	—	—	—	—	—		—	—	—	—	—	—	—	—	5	—	—	5	—	—		
—	—	—	—	—	—	—		—	—	—	—	—	—	—		8	8	—	8	—	8	—		—	—	—	—	—	—	—	—	8	—	8	—	—	8		
—	—	—	—	—	—	—		—	—	—	—	—	—	—		—	—	12	—	12	—	12		—	—	—	—	—	—	—	—	—	—	—	—	—	—		
—	—	2	—	—	—	—		—	—	—	—	—	—	—		—	—	—	—	—	—	—		—	—	2	—	—	—	—	—	—	—	—	—	—	—		
—	4	—	4	4	—	—		—	4	4	4	—	4	—		—	—	—	—	—	—	—		—	—	—	—	—	—	—	—	—	—	—	—	—	—		
6	—	—	—	—	—	6	6		6	—	—	6	—	6		6	6	6	6	6	6	6		4	4	—	4	4	4	4	4	4	4	4	4	4	4		
—	—	—	—	—	—	—		—	—	—	—	—	—	—		—	—	8	—	8	—	8		—	—	—	—	—	—	—	—	—	—	—	—	—	—		
—	—	—	—	—	—	—		—	—	—	—	—	—	—		8	8	—	8	8	8	8		—	—	—	—	—	—	—	—	—	—	—	—	—	—		
62	51	60	62	60	55	68		61	69	64	62	59	52	71		82	82	85	79	100	79	100		49	52	44	52	44	39	52	72		72	68	70	75	63	61	77

graded as follows: lesions limited to epithelium and superficial stroma, 2; changes in stroma, 4; changes in endothelium, 6; iritis, 8; cataract, 8 points.

The total number of points represents a certain amount of damage.

These evaluations have been figured out in such a way that a total of 12 represents the slightest damage in our series, and a number of 100, the greatest damage, complete loss of the eye. Thus the totals may be read as percentage of loss of the eye.

The eyes were damaged by weak, medium, strong acids and alkalis. The damage done is directly related to the strength of the chemical and the time of its action. After some orientation it was found that the action of a "weak acid" was well represented by the effect of a $\frac{1}{4}$ normal solution of sulphuric acid, applied during 10 seconds.

A prototype for a "medium" acid reaction was the use of a normal solution of sulphuric acid applied for 20 seconds.

A "strong acid" lesion was caused by the action of a 25 per cent solution of sulphuric acid during 2 minutes.

Likewise, "weak alkali reactions" were made by the action of a 2 per cent NaOH solution during 20 seconds; "medium alkali reactions" by a 10 per cent solution of the same during 30 seconds; "strong alkali reactions" by a 40 per cent NaOH solution during one minute.

Two more groups were examined after similar damage was done, viz., one in which medium acids were applied both on cornea and conjunctiva, and a second where medium alkalis were applied to cornea and conjunctiva.

A group of 21 eyes was treated according to each of the eight different ways of damaging. These twenty-one eyes were in each group divided into seven groups of three each. These subgroups were:

(1) Either rinsed with water immediately after the damage.

(2) Or rinsed with a neutralizing solution of $\frac{1}{10}$ normal alkali or acid.

(3) Or rinsed with water and treated with local drops of 2.5 per cent emulsion of cortisone 8 times daily for the first 5 days.

(4) Or rinsed with water and treated 8 i. d. by local drops of hydrosulphosol for 5 days.

(5) Or rinsed with water and treated with drops of corvasymptom 8 i. d. for 5 days.

(6) Or rinsed with water and treated by drops of adrenalone 25 per cent 8 i. d. for 5 days.

(7) Or rinsed with water and treated by local drops of 0.5 per cent pontocaine 8 i. d. during 5 days.

The total number of eyes in this table is thus 168.

Kodachrome pictures were made of the eyes in various stages.

DISCUSSION

On looking at the figures on the chart, the most striking feature is the difference between the eight different groups, while the variation within each group is relatively small. As has been stated by many others, there is a basic difference between the damage caused by acids and that caused by alkalis. This holds good for any strength of the chemical. The average figure for the damage by weak acids is 14, by weak alkalis, 38. Likewise, the average for medium acids is 31, for medium alkalis is 60. Similarly for strong acids it is 63, and for strong alkalis it shows a figure of 87 average. The two last groups show that, when in addition to the lesion to the cornea a lesion of the conjunctiva is obtained, greater damage remains, the average for medium acids being raised from 31 to 47, and for medium alkalis from 60 to 69.

Practically no difference is shown when the eyes are rinsed with a neutralizing solution instead of with water. As a neutralizing solution, $\frac{1}{10}$ of a normal solution of sulphuric acid or NaOH solution was used.

The effect of cortisone treatment is not overwhelming. However, especially in the lesion caused by medium acids, there seems to be a slight beneficial effect.

The effect of treatment with hydrosulphosol also does not make very much difference. Hydrosulphosol was chosen on account of recent publications by McLaughlin and Harley. Its effect was dubious.

Corvasymptom was used on account of the reports about it by Fischer, Wagenaar and Hodgson. The original chemical was obtained by the courtesy of Philips, Eindhoven, The Netherlands. Though in some cases the effects seemed to be slightly beneficial, no dramatic response could be observed.

Adrenalone was used because of the suggestion that the beneficial action of corvasymptom was probably due to the presence of adrenalone. The effect of adrenalone again does not show any variations with that of corvasymptom and again is not of a paramount nature.

The local use of anesthetic drops has a noticeable influence. It definitely delays the healing and even increases the damage.

In seven more eyes with strong alkali burn a paracentesis was done. Immediately after the lesion was made the fluid from the anterior chamber was let out. The final damage was definitely less than could be expected without paracentesis.

In one eye a severe burn of the conjunctiva was caused by strong alkali. Egg membrane was put in the conjunctival sac and no symblepharon developed.

CONCLUSIONS

- (1) The difference between the damage caused by acids and alkalies is clearly shown once more.
- (2) Additional lesion to the conjunctiva increases the permanent damage to the cornea.
- (3) The time of action of the damaging chemical is as important as the nature and strength of the chemical.
- (4) Various treatments with chemicals do not

show paramount beneficial effect. In fact, sometimes one gets the impression that the less chemicals are used for treatment, the better it is.

(5) Cortisone, corvasymptom, adrenalone show sometimes some beneficial effect.

(6) Local anesthetics cause delay in healing and may promote scar formation.

PRACTICAL CONSIDERATIONS

Most important remains immediate complete removal of damaging agent. Inasmuch as the differences between rinsing with water after a chemical burn of the eye and treatment with various chemicals are relatively small and inasmuch as water is always immediately obtainable, it seems logical to start any chemical burn of the eye with rinsing with luke warm water or even cold water without losing any time. Local anesthetic drops should be avoided. The use of cortisone, corvasymptom, adrenalone may be considered.

I am indebted to Dr. John Heller, Department of Medical Physics, Yale University, for his hospitality.

ARE MALPRACTICE CLAIMS PREVENTION PROGRAMS WORTH WHILE?

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I COULD answer "yes," and sit down, but you scheduled me for thirty minutes; and anyhow, I want to make a speech.

Suppose we analyze the title of this address point by point, in an effort to discern the underlying factors that cause the question to be posed.

1. FIRST, "WHAT IS TO BE PREVENTED?"

To answer this, a brief historical review is appropriate. Regan tells us that in the decades between 1900 and 1940 there was a 540 per cent increase in the number of malpractice cases that reached the

appellate courts in the United States as a whole. In the year 1940 the total number of such cases was 33. In 1953 there were 32.

These years were picked at random. They indicate a plateau, which practical experience confirms. The volume remains at least five times the 1900 incidence.

Dr. Regan's statistics demonstrate the tremendous rise in the incidence of malpractice suits in the past fifty years. Further, a little research in a law library discloses that the increase is perhaps more noticeable in the largest metropolitan centers, but that it is by no means confined to any one area. It can not be localized.

Lest physicians assume that they are being singled out by the public for special torture, it must also

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be understood that all forms of personal injury litigation have dramatically increased since World War I. Mass production of the automobile has wrought many changes, one of them being increased frequency of accidental injuries or death and increased resort to law for redress.

When people become suit conscious in general, they tend to think in terms of legal action for any and all real or fancied grievances. Fifty years ago a guest in a home would consider it ungentlemanly to sue his host, because after the third martini he wandered through a plate glass window. Now, suits of this type are not too uncommon.

With the public litigation conscious, there is an evitable tendency to commence legal action, not only when warranted, but also when there is just a bare chance of recovery; sometimes even when there is no legitimate cause for complaint.

Within the field of professional liability, the main activity that can be "prevented" is the fraudulent or false or vindictive or long-shot suit that is not predicated on just cause. The meritorious action not only cannot be prevented, but ought not be impeded. However, to separate the sheep from the goats and thereby reduce the incidence of nuisance claims would drastically curtail professional liability actions, and this of itself is a justifiable reason for a claims prevention program.

2. SECOND, "WHAT IS MALPRACTICE?"

"Malpractice" is the commonly used term to describe the liability at law of physicians and surgeons for torts committed during the course of their practice. Properly stated, it is "professional tort liability." A "tort" is a violation of one's duty to use reasonable precaution for the safety of others, resulting in an injury to another.

By law, we all are obliged at all times to be reasonably careful of the safety of others. This applies to each of us in this room. If one of you should suddenly jump up, knocking over your chair in the process, and if the chair injures the person sitting behind you, you may find yourself the defendant in a tort action for having failed to use ordinary care. Most of you, no doubt, carry insurance against this liability called "public liability coverage."

As applied to physicians, the law requires that each physician possess the average skill found amongst fellow practitioners doing the same work in his own community, and that he at all times exercise ordinary prudence and thoughtfulness in the appli-

cation of his skill to his patients. The failure to live up to these obligations is called "malpractice."

The ordinary personal injury suit against the average person involves his pocketbook only. Hence, if he is adequately insured he gives the fact of a suit against him a very superficial concern.

But to a physician, or any other professional man, a professional liability suit involves something else that is much deeper, much more important. His professional reputation, his very livelihood, his pride and his self respect are all at stake. In his mind, it is an accusation akin to a charge of dishonorable conduct. It is humiliating.

Therefore, we must not look solely to the financial aspects of malpractice.

Each physician, in order to avoid the humiliation of a liability suit, must become thoroughly familiar with the various rules of law, that together constitute the law of malpractice. He must intimately know the rules of the game.

Medical schools are not law schools. Hence the practicing physician must acquire his knowledge of the law that governs him after he is in practice, and he must either acquire this knowledge haphazardly or systematically. He will pick up his concepts either on a hit-or-miss basis from dubious sources, or he will acquire it in an orderly fashion from teachers that know at least as much as the student.

A systematic, well organized professional educational program in the field of malpractice has the possibility of achieving a tremendous reduction in the incidence of malpractice claims and suits. By educating physicians to their legal responsibilities and to the required conduct in carrying out those responsibilities, approval of the law, the public and patients may be obtained and maintained.

Malpractice has another most important facet that must be understood in any discussion of a claims prevention program.

All physicians today are, or ought to be, insured against professional liability. This insurance, however, is far from the ordinary run-of-the-mill public liability coverage.

It is true that the legal theory underlying responsibility for running down a pedestrian or for burning a patient with an ultraviolet lamp are one and the same; but beyond that, all resemblance ceases. From the moment of knowledge, the investigation, claims analysis, preparation for defense, and defense of an automobile personal injury case are standardized, not

too difficult to master, and fit into the ordinary operations of any insurance claims department or law office.

Neither the investigation, claims analysis, preparation for defense, or defense of a malpractice claim are in any way comparable to that of other personal injuries. An investigator must know enough about the practice of medicine to be able to know what to investigate when a claim of malpractice has been made. The analysis of the results of the investigation require expert medical judgment. The defense of a malpractice case in court involves specialized training in this field. The rules of evidence and the substantive rules of law are different than in the ordinary personal injury case. The lawyer must understand the medical aspects thoroughly, so that he can communicate in ordinary English to the judge and jurors the issues and facts involved.

Recently I appeared in Federal Court at Salt Lake City, and while awaiting the commencement of our trial I sat in the courtroom and observed the case that preceded us, which was a suit by the Navajo Nation against the United States for damages resulting from the destruction of Navajo horses by agents of the United States Indian Service. The witnesses were all Navajo Indians who could not speak English; and interpreting was necessary; each question was translated by the interpreter into Navajo; when the witness replied the interpreter translated the answer. The net result was that the trial took twice as long as it would have if court, jury, counsel, and witnesses all spoke in a commonly understood tongue.

This is an extreme example, but a malpractice trial is similar. Medical terminology must first be understood by counsel, and then converted into language understood by judge and jurors.

It is obvious that insurance companies that have a few malpractice policies outstanding in a community cannot afford to set up separate specialized malpractice claims departments, or employ attorneys who specialize in malpractice defense. Premium volume is too small to warrant tailormade or custom handling. To justify expenditure of funds for special treatment of malpractice policies, there must be a substantial volume, which means all or most of the physicians over a large area.

Needless to say, an insurance carrier, unless it has a large volume, cannot afford the further expense of a specialized prophylaxis or prevention program.

Fire insurance companies, with all of their business at risk, can afford to spend substantial sums of money in fire prevention programs. Workmen's compensation insurers, with hundreds of thousands of employees insured, can afford to spend money on safety programs. But an insurer with a few hundred scattered physicians insured simply can't do it.

One essential of insurance is spread of risk. The whole field of physicians' professional liability in the United States is limited to approximately 160,000 physicians. If one company insured all, the insurance base would be minor, as compared to twenty million automobile owners, or fifty or sixty million homes, or the sixty to seventy million people covered by workmen's compensation.

Hence, one of the inherent problems in malpractice insurance is the limited market, and the consequent limited ability of any one carrier to conduct the equivalent of a safety program.

3. THIRD, "WHAT IS A PROGRAM?"

In one of the States, twenty-three county medical societies now have professional liability insurance contracts with the same insurance carrier, American Mutual Liability Insurance Company. In all, close to four thousand physicians are participating. While each county has its own group contract, the program is substantially the same throughout that section of the State.

Each county has a medical committee. In the early stages of each claim against a physician, the facts are fully investigated by claims representatives of the insurer, who devote their entire time to this type of work. As claims adjusters, they are "specialists" in professional liability work.

When the case is investigated, the facts are then submitted to the society's medical committee. The members of the committee discuss and debate the case, sometimes call for more investigation, sometimes ponder their decision at length, on other occasions reach a conclusion fairly rapidly.

In any event, the committee satisfies itself that it has considered all the material facts, and then recommends either

1. That the claim has merit and that the claimant should be fairly compensated; or
2. That the facts do not disclose any medical dereliction on the part of the accused physician, and that the case should be defended.

To date, in each instance the insurance carrier has

abided by the recommendations of the appropriate committee.

The functioning of the society's committee does not, however, terminate with recommended action. If it has recommended that the case be defended, the members of the committee then actively and voluntarily assist in the preparation of the defense and in the actual trial of the case. To the defense attorney this is of invaluable aid. Incidentally, it reduces the cost of defense substantially.

Finally, the members of the various medical committees also appear before various professional audiences, and from their experiences undertake to explain to the practicing physician the legal pitfalls that beset a doctor and the conduct which should be adhered to to avoid legal liability.

The physicians who serve on these committees obtain "occupational experience." They know from having experienced specific cases what the problems are, and what information a physician needs to conduct "good practice" rather than "bad practice."

Admittedly, this program is far from perfect. A great deal more could be done, and should be done, to inform all physicians of their legal obligations, and to enable them to avoid the humiliation of a malpractice suit.

More manpower than has been available to date is no doubt needed. But at least we believe that this program is a sensible beginning. We feel that malpractice claims are intelligently analyzed, and that time and money is not wasted in endeavoring to defend the indefensible. On the other hand, unwarranted claims are discouraged in that nuisance settlements are not made. If the case is unjust it is defended; it is not settled, no matter how cheap it can be bought.

Physician participation in the trial of cases is obtained on a voluntary cooperative basis, and above all the physicians who serve on the medical committees become experienced in and aware of the problems involved, and are able to do missionary work amongst their colleagues.

The results of such a program require years to become really measurable. We feel that at least ten years, and probably fifteen years, must elapse—and we are now only in the fifth full year—before any reliable inventory can be made.

However, the results to date indicate to us who are close to the picture that we have at least halted that steady increase in the incidence of malpractice

claims and suit noted by Dr. Regan, that commenced early in the century and that has continued without interruption for fifty years.

There are a few specific observations that are somewhat collateral to the title of this address, but that are most important and ought not to be ignored in considering the value of any prevention program.

1. The incidence of malpractice claims is in inverse ratio to the degree of personal relationship between physician and patient. The more impersonal and aloof a physician is, the more critical the patients are bound to be.

2. The confidence and respect of a patient in his physician is rudely jolted when another physician makes sarcastic or derogatory comments. The roots of many malpractice cases are embedded in such remarks as "What butcher performed that operation?" or "How in the world could he have missed it?" The physician, like all of us must sell himself. The art of salesmanship is not easily acquired and the amateur usually does the wrong thing. He builds himself up by knocking others. Actually, that is poor salesmanship. The expert salesman ignores his competitor and concentrates on establishing confidence in himself.

3. Even the poor have pride, and a certain way to wound deep personal pride and self respect is for a physician to send a bill that his patient can't pay and humble the patient to the point where he has to ask for charity. Many a malpractice case has its roots in the thoughtless handling by a physician of the financial side of his practice. The bill doesn't have to be exorbitant to cause anger and resentment; it can be reasonable, but if it humiliates, resentment is immediately aroused. A little tact and a little inquiry before billing could save many a headache.

4. Lawyers soon learn not to believe everything that their clients tell them. People have a habit of stating as fact that which they would like to believe, not the cold cruel reality. Many physicians find it difficult to realize that the tales their patients tell them may not necessarily be true. Consequently, a patient who is shopping will tell a physician a tall story about treatment that he received from another doctor; the physician accepts it as true, and comments accordingly; next year he is in court.

5. Inherently, malpractice prevention is entwined with malpractice insurance. The insurance obtained must be adequate and the carrier interested. Insurance is a commodity, it comes in different prices and packages and is produced to fit a market. If one

buys the cheapest policy, one gets exactly what is deserved—the lowest quality. For physicians to buy malpractice insurance solely on the basis of price, is to my mind, foolish. Recently, a physician cancelled his group coverage because he could save \$10 elsewhere. He said, “We feel that with today’s competitive prices we have to be on the lookout for savings.” So will his carrier when he is faced with a claim of malpractice. Then he will learn. A malpractice prevention program and basement bargain sales are incompatible with each other. A safety program costs money, whether it involves your home, factory or profession.

These, then, are some of the reasons why a prevention or safety program is worthwhile and why to undertake it requires a group, rather than individual, action.

If by now, anyone in the audience doubts the need for control of “malpractice” suits, allow me to quote from the May, 1954, issue of the *American College of Radiology News Letter*:

“There are many reasons why the entire medical profession today finds itself in the same position that radiology was in 20 years ago. Here are some of the recent causes that have gone into the pot to make hospital and physicians’ liability insurance even more undesirable from the underwriters standpoint: increased demand for medical and hospital care; legislation increasing hospital liability; specialization, excessive fees; increased public “claim consciousness;” bad hospital public relations; hospitalization insurance; dollar “madness;” court interpretations

broadening liability in this field; increased costs of legal work and investigation.”

“The most potent factor; however, is the ever spiraling inflation and dollar devaluation—to which there seems to be no end—and which has resulted in fantastic judgments being rendered by juries in personal injury and malpractice suits.”

Again, quoting from the same article in connection with the problem of lack of interest by insurance carriers:

“Some few of the companies are reluctantly writing business at the Bureau rates. One company will write for only their own agents and will cover x-ray therapy, providing the assured has been certified by the American Board of Radiology or is a member of the American Roentgen Ray Society or the Radiological Society of North America. Another company will write for its own agents only and will not write or renew existing policies for brokers. In addition, the applicant must promise the company all of his insurance business as collateral.”

Physicians are in jeopardy until the insurance industry again is interested in insuring them. This will not occur unless and until the risk in professional liability insurance is lessened materially. The risk won’t decrease of its own accord. A real, vigorous and widespread but grass roots program—by the medical profession itself—to educate its members to their legal duties, to advise and assist when trouble brews, and to fight relentlessly all unjust claims, is the only prudent course of action, if disaster is to be avoided.

THE TREATMENT OF MYOCARDIAL INFARCTION WITH SHOCK

Advantages and Disadvantages of Use of Levophed

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THE treatment of patients who have sustained an acute myocardial infarction with shock has been and continues to be a difficult problem confronting the physician.

The mortality of those patients who manifest severe shock following acute myocardial infarction has been estimated to be about 80 per cent.^{1,4} However, with modern treatment this mortality can be significantly decreased.¹ The cardinal sign in the diagnosis of shock is an extreme fall in blood pressure¹ but this does not of itself indicate that treatment is necessary in this condition unless other manifestations of shock are present. In the treatment of shock following acute myocardial infarction the use of intravenous^{1,2,3} L-Arterenol (Levophed) given by continuous intravenous drip has helped to lower the mortality in such cases. Such drugs as Wyamine and Neo-synephrine^{4,5,6,7} can be used in an attempt to combat shock in myocardial infarction but where these do not give the desired effect the drug of choice is Arterenol.^{1,3,4} In addition to intravenous Levophed it may be necessary to give blood transfusions and plasma. Warning is given that the intravenous use of Arterenol may cause severe necrosis and sloughing because of its vasoconstrictor property,^{1,2,3} especially if there is any extravasation.

Kurland and Malach² state that Norepinephrine (Arterenol) produces a generalized arterial capillary and venous constriction. It has neither the calorogenic effects of epinephrine nor its hyperglycemic action. Striking rises in oxygen tension in areas of myocardial ischemia have been demonstrated after its intravenous administration. Complications arise due to the intense venospasm^{1,2,3} and ulceration of the skin can occur. These difficulties may arise even though no leakage occurs around the needle.

Oblath and Griffith³ point out that shock is one of the most important immediate complications following acute myocardial infarction. Its mechanism is not agreed upon but it is generally considered to be due to decreased cardiac output, reflex peripheral

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SUMMARY

A case of shock due to myocardial infarction in which intravenous Levophed was used has been presented. The patient recovered and it is felt that he did so because of the intravenous use of Levophed. If no treatment of this type had been given, it seems almost certain that this patient would have died. However, in spite of good nursing care and proper management, he developed areas of slough on his left arm and on both legs. This may be considered a small price to pay for the life-saving result which was achieved. Alternate methods of treatment in cases such as this one have been discussed. These methods are the use of intravenous Wyamine or Neosynephrine in sufficient concentration to give the desired results; that is, to maintain the blood pressure at optimum levels. It is hoped that with the use of such treatment life-saving results may still be achieved and complications avoided.

circulatory failure with impaired venous return to the heart, or a combination of both. The longer the duration of shock, the worse is the prognosis.^{1,3} It is felt that Noradrenaline^{1,3} is the agent of choice. This is administered as a continuous intravenous drip at a rate adjusted to maintain blood pressure at the desired level.^{3,4} The important^{1,2,3} complications of such therapy are phlebitis and slough, but because of the gravity of the situation these complications should not deter one from treatment. Wyamine and Neosynephrine^{1,3} are useful agents but their usefulness is limited in that they are not as well suited for continuous intravenous drip as is Noradrenaline and are too rapidly metabolized for intermittent use. If Neosynephrine³ is used intravenously, it is recommended that it be used in doses of 2 to 7 mg.

Cardiac infarction is more often than not accompanied by shock.⁴ Usually the shock is transient and

passes off as the pain abates under the influence of morphine, but where shock persists death ensues in about four out of five cases.^{1,4} It is in these cases that intravenous infusions of glucose, plasma, blood, and pressor drugs are indicated.^{1,4} A series of six patients is presented who were suffering from shock in myocardial infarction in which infusions of L-Noradrenaline were given.⁴

It is interesting to note that as high as 64 milliliters of Levophed in a liter of glucose in distilled water as an intravenous drip was given in one of the six cases.⁴ There was no hesitancy in increasing the concentration of L-Noradrenaline when it was indicated. The presence of a nurse capable of measuring the blood pressure reliably was felt to be essential. Throughout the whole period of treatment vigilant attention had to be given to the drip rate which might vary with corresponding and perhaps dangerous fluctuations in blood pressure. The blood pressure should be kept, if possible, between 100 and 110 mm. systolic. In spite of the fact that as high as 64 milliliters of L-Noradrenaline were given by infusion in a 1000 cc. solution, no mention was made of any complications such as phlebitis or necrosis about the veins which were used.⁴

Shock due to acute myocardial infarction may be treated by the use of an intravenous solution of 100 cc. of distilled water with 5 per cent glucose in which 35 to 70 mg. Wyamine is added.⁵ This should be given at a slow intravenous drip over a period of two hours and the dose and rate of the infusion should be regulated according to its effect on the blood pressure. Later intramuscular injections of 25 mg. of Wyamine may be needed. This is given every one to two hours as necessary.

Cardiogenic shock, unlike traumatic or hemorrhagic shock, causes a reduction in cardiac output which cannot be attributed to a reduction in the effective circulating blood volume and a decrease in the venous return.⁶ In fact, in cardiogenic shock the venous return seems to be too great for the failing left ventricle so that pulmonary edema and congestive heart failure are often observed during the collapsed state. Norepinephrine and Neo-synephrine are potent pressor agents that elevate the blood pressure by producing arteriolar constriction without greatly depressing the coronary blood flow or myocardial metabolism. Digitalis glycosides are very important in combating the edema that supervenes in cardiogenic shock.

Chassin⁷ in his discussion of shock due to myo-

cardial infarction states that his treatment of choice is digitalization plus the intravenous drip infusion of 6 cc. of 1 per cent solution of Neo-synephrine in 1000 cc. of distilled water with 5 per cent glucose. He stated that Wyamine, Arterenol, and other pressor drugs could be used but felt that in his hands the best results were achieved with the above method. It will be noted that 6 cc. of 1 per cent solution of Neo-synephrine contains 60 mg.

CASE

J. M., white male, age 72, entered the Manchester Memorial Hospital on November 21, 1953 at 11:30 A. M. complaining of severe substernal pain which radiated into the neck and had lasted for several hours. There was no history of previous anginal complaints but the patient stated that he had been treated for high blood pressure for several years. The physical examination revealed an elderly and slightly obese white male lying in bed somewhat orthopneic. The skin was very cold and clammy. The lips were cyanotic. The blood pressure was 110/65. The heart sounds were very faint and of poor quality. The apical rate was 84 per minute and regular. The chest was symmetrical and expanded equally. The lungs were clear. There were no rales. Expiration was prolonged. There was no increase in liver dullness nor was the liver palpable. The extremities revealed cyanosis of the finger and toenails. There was no edema.

A provisional diagnosis of acute myocardial infarction with shock was made. The blood pressure was taken every half hour. From 12:00 noon until 1:30 P. M. it remained about the same, i.e., 98/70. Between 1:30 and 2:00 P. M. the blood pressure dropped to what was recorded as nonobtainable. At this time an intravenous of 1000 cc. of 5 per cent glucose in distilled water with one ampule of Levophed was started at the rate of 20 drops per minute. This was given in a vein in the cubital fossa of the left arm. The patient was also digitalized. At 3:30 P. M. the blood pressure was 60/? The pulse was irregular and 144 per minute. At 4:30 P. M. the skin was cold and clammy and the rate of infusion was increased to 40 drops per minute. A blood pressure of 128/100 was recorded at 5:00 P. M. At about 9:00 P. M. there was some infiltration of the intravenous infusion and therefore it was discontinued. The blood pressure remained fairly well until about 10:00 P. M. when it again seemed unobtainable. Another intravenous of 1000 cc. of distilled water with 5 per cent glucose and one ampule of Levophed was started. The blood pressure gradually rose to 110/90. The patient's color was good and the intravenous was running satisfactorily. The patient's general condition seemed poor but the blood pressure was well maintained until about 5:00 P. M. of November 22, the patient's second day in the hospital, when it began to drop and his general condition seemed to deteriorate. Another intravenous of Levophed was started. At 6:00 P. M. the blood pressure was 130/100. At 7:00 P. M. it was 110/80. At 8:00 P. M. it was 110/80. The patient's general condition seemed to improve.

At 8:30 P. M. of the day of November 23, patient's third day in the hospital, another intravenous of Levophed was started, because of deterioration of the blood pressure. Following this his blood pressure remained fairly well con-

trolled and when this intravenous was finished it was felt that it was no longer necessary to give this type of treatment since the blood pressure remained around 120 to 130 systolic over 70 to 80 diastolic. The patient's general condition, however, was still poor, and because the heart rate was irregular he was given quinidine.

On November 24, 1953 the patient, although doing poorly, maintained his blood pressure at a satisfactory level. On November 25 at 1:00 A. M. his condition suddenly changed for the worse. His blood pressure again became alarmingly low and another intravenous of Levophed was started. At 6:00 A. M. it was noted that the patient's condition had improved. His blood pressure ranged from 100 to 110 systolic over 70 to 80 diastolic. He was given intravenous Levophed infusions for the maintenance of his blood pressure and a final one was given on November 27. On that day also an electrocardiogram was taken which revealed runs of atrial fibrillation and nodal rhythm with evidence of myocardial ischemia and right bundle branch block. On December 1, 1953 an electrocardiogram revealed atrial fibrillation,

intraventricular block and left ventricular strain. On December 5, 1953 an electrocardiogram showed that normal sinus rhythm had been established and the ventricular rate was 60. There was intraventricular block and evidence of left ventricular hypertrophy and strain. Although the electrocardiograms did not reveal definite evidence of myocardial infarction, because of the history and clinical findings it was definitely felt that a recent myocardial infarction had taken place. Beginning on December 13 it was noted that the patient was having areas of swelling, and complaining of pain and numbness in both legs where the intravenouses were given. He also had areas of swelling and complained of numbness in both cubital fossae. He was treated for this. This gradually grew worse and areas of ecchymosis, swelling, inflammation and necrosis developed in the left cubital fossa and on both legs. He was treated for this condition. By December 26 there was considerable drainage from the legs. The left arm and right leg were treated by debridement. When the photographs which are presented below were taken, the patient was in bed and doing well.



FIGURE 1
Left arm



FIGURE 2
Left leg



FIGURE 3
Right leg

It can be seen in the above photographs that there are large areas of ulceration and necrosis.

DISCUSSION

From what has already been said it would appear that all agree that shock in acute myocardial infarction carries with it a high mortality. It is also apparent that in many cases the shock corrects itself after a period of one or two hours. However, after this period of time, if the shock still persists, the mortality rate rises the longer this condition is allowed to go untreated. It cannot be said that the mortality rate is reduced to a satisfactory level even in those cases of cardiogenic shock that are treated by what are considered to be the best available methods today. It should, however, be noted that the treatment of cardiogenic shock by means of intravenous Levophed carries with it certain calculated risks. These risks, although not dangerous to the life of the patient, are certainly of sufficient gravity for us to ask ourselves as to whether we are not justified in

hesitating to use this drug before other measures have been tried and found wanting.

The use of Neo-synephrine and Wyamine have been mentioned and recommended in the treatment of cardiogenic shock. It is quite possible that their use has not given the desired results in many cases because they have not been given as intravenous infusions in sufficient strength. Chassin⁷ as we have stated feels that he gets good results with an intravenous drip of 1000 cc. of distilled water with 5 per cent glucose to which 60 mg. of Neo-synephrine have been added. Hellerstein and Brofman⁵ tell of the use of Wyamine in strengths of 35 to 70 mg. in 100 cc. solution of distilled water with 5 per cent glucose which is given by intravenous drip over a period of two hours. Might not better results be achieved here by setting up a continuous intravenous drip of 1000 cc. of distilled water with 5 per cent glucose to which 35 to 70 mg. of Wyamine per 100 cc. have been added? With these thoughts in mind it might be well first to try intravenous Neo-synephrine or Wyamine or both before resorting to the intravenous use of Levophed. In this way we may be able to save patients in shock due to myocardial infarction and reduce to a minimum the distressing complications such as those shown on the photographs.

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FOREIGN BODIES IN URINARY BLADDERS OF CHILDREN

Case Report

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CASE reports in the literature indicate that foreign bodies in the urinary bladders of children is not a rare condition.¹ That has not been our experience at Manchester Memorial Hospital. The appearance of such a case prompted us to present a brief review of some of the literature on this subject and the details of this case.

The mode of entrance into the urinary bladder of most foreign bodies is by self introduction via the urethra as a mean of masturbation, especially in the female sex. The list of foreign bodies recovered from the urinary bladder in large clinics is astounding. Some of the most common of these are hairpins, safety pins, bobby pins, pencils, needles, tooth picks, rubber tubing, gum, paraffin, sealing wax, candle wax, nails, wire, straws, stones, and seeds of plants. Hairpins^{1,2} are probably most commonly involved. Less commonly the foreign body is a shell fragment, a splinter of wood or a bony spicule from a fracture. On rare occasions foreign bodies, such as sponges, sutures, swabs and small surgical instruments are left in the bladder after a surgical procedure. Swallowed objects, such as tacks, bits of glass and needles have been recovered from the bladder after they had eroded through the gut and bladder wall. A dermoid cyst of the bladder wall may introduce hair, teeth or fetal bones. Malone³ reports an interesting case in which a tooth found in the bladder was thought to originate from such a cyst but, on further examination, was found to have a filling, thereby establishing its true source.

The history often is of little value. The feeling of shame or fear of punishment usually prevents the patient with a known foreign body in the bladder from giving a history of such and seeking aid in its removal. Only after they are shown what had been removed from the bladder do they admit its mode of entrance.¹

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SUMMARY

A brief review of some of the literature concerning foreign bodies in the urinary bladders of children is presented together with a case illustrating the situation. All cases of persistent hematuria and/or pyuria should have a complete genito-urinary work-up, including an intravenous pyelogram and, if necessary, cystoscopic examination.

The symptoms of a foreign body in the urinary bladder are similar to those of a urinary bladder calculus. The onset of symptoms may begin almost at once after introduction or may be delayed for a considerable length of time. The symptoms of pain, urinary frequency, urgency, great straining, dribbling and sometimes complete urinary obstruction brings the patient to the physician. Pain is found in nearly every case. It may be constant or it may be most severe when the patient is expressing the last few drops of urine. Changing the posture may be of some benefit. In the upright position the stone may rest on the trigone, causing extreme irritation and tenesmus with the last few drops of urine. This may cause the patient to grasp his external genitalia and scream. Writers in the older literature referred to this as the "fit of the stone."¹ Assumption of the horizontal position often relieves this pain and children and adults soon learn that this and other weird positions, such as lying on the side or on the back or in the knee-chest position while urinating, does away with this pain. Some children with a foreign body and stone in the bladder experience a sharp pain in the perineal region while sitting down. In

only two conditions is there an absence of symptoms with any regularity. They are when the stone-foreign body is immobile as when it is caught in a bladder diverticulum, or when the stone is so large that it completely fills the bladder. The constant symptoms referable to the bladder may interfere with the child's nutrition, development and activity. The child may look and act older than its chronological age. Examination of the urine shows gross or microscopic pus and blood.

The diagnosis of foreign body in the bladder is easier to make when a correct history is given. Although rectal and vaginal palpation are of aid, cystoscopic and roentgenographic findings are the most reliable means of diagnosis. Calcium salts nearly always precipitate about a foreign body, thereby making them radio-opaque. This is of great aid in those cases where the foreign body is radiolucent. By combining x-ray and cystoscopic examinations, a correct diagnosis can be expected in approximately ninety-seven per cent of cases.³

The pathologic changes are due to mechanical irritation and infection. Urea-splitting organisms are commonly found in bladders that are obstructed and unable to drain completely, thereby helping to produce an alkaline urine which aids in precipitating calcium salts about the foreign body.¹ Occasionally a pointed foreign body may perforate the bladder wall forming a vesico-vaginal or vesico-enteric fistula.¹ Other changes found are pericystic and periurethral abscess or urethral stricture.

The treatment of choice is the removal of the foreign body and its associated calculus and the institution of chemotherapy and/or antibiotics. Small bodies and stones may be removed by forceps through an endoscope. Larger foreign bodies and stones are probably best removed via a suprapubic cystotomy. This method is also preferable in cases which are complicated by perforation or impaction.

REPORT OF A CASE

A 5 year old, white, female child was admitted to Manchester Memorial Hospital with the chief complaint of urinary frequency and burning, two months in duration. Family and past history were noncontributory. Upon questioning she stated that she had a sharp, stabbing pain in the perineum when she sat down. The urinary frequency and burning became progressively more severe. No history of insertion of a foreign body into the bladder was obtained. Previous antibiotic therapy failed to clear up the pus and blood found in the urine. Physical examination revealed a well developed, thin, white girl who looked older than her given age. There was a mass in the suprapubic portion of

her abdomen. Pressure on this mass caused the patient to feel the urge to urinate.

Laboratory work showed the hemoglobin to be 11.3 gm. per cent, RBC 4.13 million, WBC 16,300 with 68 per cent neutrophils and 32 per cent lymphocytes. NPN 39 mgs. per cent. Routine urine showed 3 plus albumin. No sugar was present. Microscopic examination showed the urine to be packed with pus cells. Urine culture grew out *E. coli* and *proteus* which was 4 plus sensitive to Furadantin.

When the bladder was catheterized for residual urine, 35 cc. was obtained. The urine had a strong ammoniacal odor. An intravenous pyelogram showed a hairpin and large calculus in the pelvis and was interpreted to be in the urinary bladder. (See Figure 1.) Also there was complete duplication of the right side of the urinary tract. On the left side there was slight dilatation of the ureter and some blunting of the calices of the kidney. Since the excretory cystogram revealed the foreign body and calculus to be definitely in the bladder, cystoscopy in this case was not thought advisable or necessary. This illustrates the value of an intravenous pyelogram in all cases of persistent pyuria and hematuria.



FIGURE 1
Pyelogram before operation

A suprapubic cystotomy under general anesthesia was done to remove the foreign body and calculus. This approach was selected, not only because of the size of the calculus and the foreign body, but also because a 5 year old child's urethra is too small to permit the introduction of

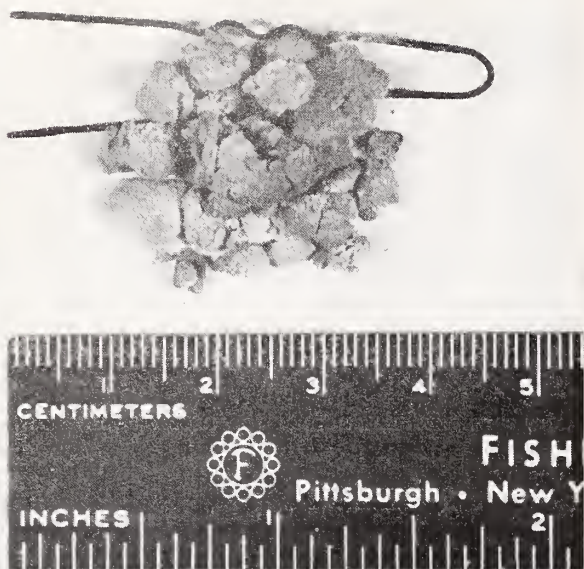


FIGURE 2

Hairpin and calculus reassembled after operation

any satisfactory lithotrite or operative cystoscope for the removal of large foreign bodies. The child's bladder was closed per primum, despite the obvious infection, and a Foley catheter was left in the bladder for drainage. Furadantin therapy was begun. Surgery was by C. W. J. Postoperatively her convalescence was complicated by fever and urine draining from the surgical wound after the Foley catheter was removed. Penicillin and dihydrostreptomycin were added at this point. The catheter was reinserted, the fever fell and the wound healed well. Culture and microscopic examination of the urine at this time were negative. The catheter was again removed. The patient voided without difficulty. She was discharged in three days to her home, where she made a complete and uneventful recovery.

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AN OUTBREAK OF FOOD-BORNE DISEASE DUE TO SALMONELLA ORANIENBURG

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ON Tuesday, September 8, 1953, the day after Labor Day, it was reported to the Connecticut State Department of Health by the local health officer that an outbreak of illness had occurred among the members and guests of one of the lake associations within the State following a dinner served on the previous Saturday. An investigator was immediately despatched to the scene. On this and the succeeding days it was learned that about 160 people had attended the dinner served at 7:00 P. M. on Saturday, September 5, 1953. No complete list of those present was available. However, some information was obtained on 107 people who had attended the dinner. Of these, 91 or 56.9 per cent of the total number at the dinner and 85.0 per cent of those contacted were ill. Complete epidemiological records were obtained on 82 people who were ill. The times of onset of illness for these people ranged from eight to fifty-eight hours after consumption of the dinner with 67, or 81.7 per cent, of them occurring eight

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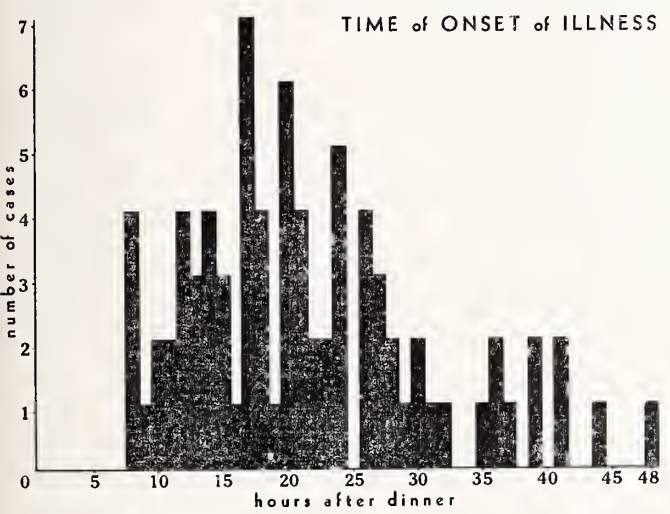
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SUMMARY

This report describes the investigation of an outbreak of food infection due to *Salmonella oranienburg* among persons who attended a dinner on September 5, 1953. Of the approximately 160 people who attended the dinner, 107 were contacted and 91 gave a history of illness with the time of onset in most cases falling between 8 and 30 hours after the meal. The vehicle of the infection was found to be turkey. Two possibilities as to the way the turkey may have become contaminated are mentioned.

to thirty hours after the meal. The incubation period for salmonellosis in epidemics, as given by "The

Control of Communicable Diseases in Man," a report of the American Public Health Association, is six to forty-eight hours. The following graph shows the time of onset of illness for 79 on whom the incubation period was 48 hours or less:



Only three persons contacted gave a time of onset indicating an incubation period longer than forty-eight hours. One of these, who became ill fifty-one hours after the dinner, was the mother of two children who became ill twenty-four and twenty-nine hours, respectively, after eating. Another who became ill at fifty-one hours was the teen-age sister of one of the earliest cases. The last who became ill at fifty-eight hours was the mother of a young man whose illness began at noon on the day after the dinner. All of these may have been secondary cases.

The illness was characterized by diarrhea, griping abdominal pains, nausea, vomiting, fever, severe generalized muscular pains, and headache. The temperature in some cases rose to 104°-105° F. Bowel movements were watery but without blood or mucus. Eight people, all adults, were hospitalized because of the severity of the illness. The illness in the milder cases lasted only twelve to twenty-four hours. Some of those more severely afflicted continued to have symptoms for three to four days and a few developed a typhoid-like syndrome ten to fourteen days after their original illness. No deaths occurred. Stool specimens were collected on seventeen of the persons who were ill. Cultures on all of these were positive for *Salmonella oranienburg*. One of these people was found to have a stool positive for *Salmonella choleraesuis*, variety *Kunzendorf*, as well as *Salmonella oranienburg*. One person who had at-

tended the dinner and showed no symptoms of illness also submitted a stool specimen which was positive for *Salmonella oranienburg*. One clot culture positive for *Salmonella oranienburg* was found on blood submitted for typhoid-paratyphoid agglutinations from one of the persons who also had a positive stool culture. None of the people who were ill are known to have become permanent carriers of the organism. Two were found to have positive stools 52 and 58 days, respectively, after they became ill but both of these later cleared up.

The dinner, prepared by a group of eight women, consisted of canned tomato juice, roast turkey with dressing, gravy, mashed potatoes, frozen mixed vegetables, fresh tomatoes and cucumbers with mayonnaise, rolls and butter, several kinds of cake and coffee. No samples of food were available for culture. None of the women who prepared the meal gave a history of any preceding illness and none were clinically ill following the dinner. Two stool specimens were collected on each of these women. Five were completely negative. Two showed *Salmonella oranienburg* on the first specimen but not on the second, and one showed *Salmonella oranienburg* on both specimens. These three all "tasted" the food before serving and may have developed subclinical infection in this way.

The following tables show the foods eaten by the 82 people who were ill and the 16 people who were not ill on whom complete records were obtained, and the attack rates by type of food eaten. The only food eaten by all of those who became ill was turkey. Gravy was eaten by all except one of those who became ill, but, as will be explained later, the original turkey gravy was discarded and canned gravy used.

EFFECT OF FOODS EATEN				
	ILL Total = 82		NOT ILL Total = 16	
	NO. EATING	NO. NOT EATING	NO. EATING	NO. NOT EATING
Tomato juice	79	3	16	0
Turkey	82	0	14	2
Dressing	60	22	12	4
Gravy	81	1	14	2
Mashed potato	78	4	16	0
Mixed vegetable	77	5	16	0
Tomato	64	18	14	2
Cucumber	49	33	13	3
Mayonnaise	36	46	12	4
Rolls and butter.....	64	18	14	2
Cake	76	6	16	0

ATTACK RATES BY SINGLE FOODS EATEN

TYPE OF FOOD	PERSONS EATING	NUMBER SICK	PER CENT SICK
Turkey	96	82	85.4
Gravy	95	81	85.3
Dressing	72	60	83.3
Tomato juice	95	79	83.2
Mashed potato	94	78	83.0
Mixed vegetable	93	77	82.8
Cake	92	76	82.6
Tomato	78	64	82.1
Rolls and butter.....	78	64	82.1
Cucumber	62	49	79.0
Mayonaise	48	36	75.0

The turkey, dressing and gravy for this meal were prepared by a catering firm in Hartford. They were picked up at about 1:00 P. M. on Friday, September 4, an exceedingly warm day, by two members of the food preparation committee, one of whom later showed one stool specimen positive for *Salmonella oranienburg*, and taken directly to the town hall of the town where this outbreak occurred, a trip of about 40 minutes by car. These foods were immediately placed in their original containers in the refrigerator of the town hall which reportedly had about 18 hours earlier been turned from the "vacation" setting to the number one setting.* The turkey, dressing and gravy were removed from the refrigerator between 5:00 and 5:30 P. M. on the evening of the dinner. The turkey and dressing were transferred to roasting pans and immediately put in a "slow oven" where they remained until dinner was served. Because the gravy smelled sour, it was discarded and canned beef gravy substituted.

Investigation of the catering firm supplying the turkey, dressing and gravy was begun by the Hartford Health Department on September 8, 1953, three days after the dinner was served. These were the only items supplied by the combination market-caterer, and were completely prepared by two of the delicatessen kitchen cooks in this establishment. Neither of the two cooks had any apparent fresh or healing lesions. Both denied having had fever, sore throat, diarrhea, vomiting or otherwise feeling sick in the preceding two weeks. Two stool specimens on each man were negative for *Salmonella*.

*On September 10, 1953, an investigator visited the town hall and found the refrigerator again set on "vacation" with an internal temperature of 55° F. Twelve hours later with the refrigerator again set at number one, the internal temperature was 40° F.

The facilities and equipment of the firm on this and previous inspections appeared adequate, well maintained and clean. Convenient handwashing and potwashing sinks are provided. Temperature of all refrigerators were below 40° F. on September 9, 1953, and storage capacity appeared to be more than adequate at that time. No plumbing, insect, or rodent problem was evident.

All foodstuffs, with the exception of a flavoring agent used in the gravy, were provided from the firm's regular retail store supply. A specimen of the flavoring agent showed negative laboratory results. No samples of the involved turkeys, gravy or dressing were available at the time of investigation.

The following information was obtained from the management and employees of the catering firm. Seven turkeys, weighing a total of 88 pounds, were used to prepare the order for the lake association dinner. These birds, together with the birds for retail sale, were eviscerated in the meat department by one of the market's butchers on Wednesday, September 2. All further preparation was completed by one of the two cooks in the delicatessen kitchen. On Thursday, September 3 the turkeys were taken out of the butcher's refrigerator, washed both internally and externally, and at about 9:00 A. M. were placed, unstuffed, in an oven set at 400° F. At 12:30 P. M. they were removed from the oven, allowed to cool at room temperature for a short period, and at 1:15 P. M. were placed in the delicatessen kitchen's refrigerator. The following morning, Friday, September 4, the cook washed that day's set of raw birds and placed some of them in the oven. After this, at 9:15 A. M., the cooked turkeys were taken out of the refrigerator, sliced, put on two trays, and placed back in the refrigerator. The retail birds were removed to the retail delicatessen counter as needed. How adequately the cook washed his hands between handling the raw and cooked birds, and how adequately storage containers were sanitized is speculative. However, the raw and cooked birds were stored in different refrigerators and different areas of the kitchen were used in washing the raw birds and slicing the birds cooked the previous day. Whether or not a common knife was used on both the cooked and uncooked birds can not be established. At 1:00 P. M. the order was called for and removed from the refrigerator.

In an earlier survey the Hartford Health Department had found that a 22 pound stuffed turkey placed in an oven of 425° F. directly from overnight

storage in a refrigerator took three hours and forty-five minutes to reach an internal temperature of 140° F. On this basis, any salmonella organisms in these unstuffed turkeys of 12 pound average weight, after three and one-half hours in a 400° F. oven, would be expected to have been destroyed.

The dressing and gravy were prepared completely by the second cook the same morning as the turkey was sliced. The dressing was prepared by soaking stale bread (from bakery counter, and stored in refrigerator until used) in water twenty minutes, draining and mixing with cooked turkey livers, chopped onion, salt, pepper, poultry seasoning, and fresh eggs. All eggs were said to appear in satisfactory condition after cracking. This mixture was placed in trays to a thickness of about one inch and baked in an oven set at 400° F. from 8:30 to 10:20 A. M. This was transferred immediately to either a clean 10 quart frozen egg or frozen fruit can and left at room temperature until called for at 1:00 P. M.

The gravy was prepared from the turkey stock collected from turkeys baked the previous day, and handled in the same manner as the turkeys, but was stored in an 8 gallon pot. Three gallons of the turkey stock and four gallons of water were heated to the boiling point, salt, pepper, flour and flavoring agent added, and reboiled for five minutes. After straining, two and one-half gallons were placed in a clean 10 quart frozen fruit or egg can and left at room temperature until called for.

It is interesting to note that six other turkey orders, and about twenty-five retail sales were made from the same group of turkeys, dressing and gravy. Neither the Hartford Health Department nor the manager of the firm received any complaints of food poisoning other than from the lake association.

It was impossible to determine exactly how the turkeys were infected. One possibility which comes to mind is that the meat was contaminated by the woman who helped transport the food from Hartford to the lake and who was later found to have one positive and one negative stool. The second possibility is that it was contaminated by the chef who on September 4 handled raw turkeys and then sliced the cooked turkeys, possibly without washing his hands. The meat from seven turkeys, averaging 12 1/2 pounds apiece, was put in only two pans. Even though these were immediately placed under refrigeration it would have taken a lengthy period of time for the center of the mass to attain proper

temperature to inhibit bacterial growth. Smaller quantities of meat handled in a similar fashion may have caused no illness.

Salmonella oranienburg has previously been known as a causative organism in human illness. Seligmann, Saphra and Wassermann¹ found it in 6.8 per cent of the human cases in America, and found it in pneumonia, meningitis, cholecystitis, appendicitis and abscesses as well as gastroenteritis.

Rubenstein, Feemster and Smith,² reporting on 811 positive salmonella cultures found in Massachusetts from January 1937 to July 1943, describe no epidemics due to Salmonella oranienburg but found 13 of 295 sporadic cases of salmonellosis due to this organism. In investigating the contacts of these cases 15 more positive cultures were found, 13 of these apparently with subclinical infection. These investigators also reported two permanent human carriers of Salmonella oranienburg with positive stools over periods of 104 and 135 weeks, respectively. Among the 12,331 cultures from 47 animal species and other sources studied by Edwards, Bruner and Moran³ from 1934-47, Salmonella oranienburg was one of the more frequently encountered types, composing 5.2 per cent of the total cultures and 7.4 per cent of the cultures from man. They found Salmonella oranienburg in 229 cultures from 127 human outbreaks. Of the 645 cultures of Salmonella oranienburg, only 100 were isolated from sources other than man, chickens and turkeys. High incidence of Salmonella oranienburg has been described in Canada⁴ where of 317 cultures identified as Salmonella at the Canadian Salmonella Typing Center in a 27 month period ending March 31, 1947, twenty-five or 7.9 per cent were identified as Salmonella oranienburg. In Connecticut⁵ the incidence over a 45 month period ending September 30, 1942 was somewhat lower. Of a total of 358 new isolations of Salmonella, 11 or 3.1 per cent were Salmonella oranienburg.

Next to man, more varieties of salmonella have been found in turkeys than in any other animal. Of the 111 types of salmonella studied by Edwards, Bruner, and Moran,³ 94 types were found in man and 50 in turkeys. The increasing production of turkeys throughout the country indicates that human salmonellosis from turkeys may continue to be an increasing problem in public health. During the period from 1910 to 1920 only about three million turkeys were raised annually.⁶ Since 1920 increasing numbers of turkeys have been produced each year so that during the last few years about thirty million

birds have been raised annually.⁶ Symptoms of salmonellosis in turkeys are not sufficiently characteristic to make a definite diagnosis. Droopiness, huddling near the heating element, ruffled feathers and diarrhea may be observed.⁶ Losses among young birds vary greatly depending upon the general sanitary conditions. Poults maintained in clean quarters may not suffer heavy losses. On the other hand, the mortality may vary from 10 to nearly 100 per cent.⁶

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SERVICE BENEFITS VS. INDEMNITY BENEFITS

The Case For Service Benefits

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THE question of whether Blue Shield Plans should provide service benefits or indemnity payments affords an interesting topic for discussion. I do not believe it is worthwhile, however, to devote this session of your training here at the institute to the discussion of an academic question. I believe we should try to analyze the situation and establish definite landmarks for the future course of Blue Shield. I do not think I am alone in feeling that eventually all Blue Shield Plans must follow a single pattern; they must all render service benefits or that concept must be abandoned. We are, therefore, not engaged in idle discussion but in an attempt to chart the better course which Blue Shield should follow.

While there are many aspects to the problem, some of which are very familiar to you and others we hope to bring to your attention today, I believe there should be only a single criterion in deciding the question and that is, which type of plan will best serve the interest of the American people.

Before entering upon a detailed discussion of the merits of service benefits, I think it would be helpful to supply a certain amount of background by

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SUMMARY

1. Service benefits are all that Blue Shield has to sell.
2. Service benefit income levels must be realistic.
3. Participation by physicians must be voluntary but the operation of the plan should provide practical advantages for the participating physician.
4. If physicians provide service benefits they must be in a position to determine the fee schedules and the professional policies governing their services.

reviewing briefly the problems which nonprofit medical care plans were established to meet. The plans themselves are of such relatively recent origin that the circumstances surrounding their establishment are well within the memory of most of us.

Changing techniques and the advent of the era of specific treatment in medical practice resulted in a much more satisfactory, but also a much more

complex and expensive type of medical care for the American people. The influence of two world wars and the constantly rising spiral of inflation contributed further to the ultimate cost of medical care. Under the influence of the political thought which dominated the country for over twenty years the American people were being presented, to an ever increasing degree, with the merits of various compulsory, government-controlled systems of medical practice. The benefits which were promised under such programs were certainly attractive and seemed to many people to answer the needs of the situation.

Physicians, always slow to act on nonmedical matters, were finally convinced that nothing but a direct frontal attack would enable them to preserve the traditional freedom of medical practice which they sincerely felt was necessary to the maintenance and extension of the high level of medical care which had been developed in this country.

One phase of the attack upon the social planners was the establishment of medical care plans sponsored by units of the organized medical profession—municipal, county, or state. With the success of these plans and their development in many locations throughout the country came the establishment of a central organization for the correlation of effort which we now know as Blue Shield Medical Care Plans.

There are three principals involved in the medical care problem: The member-patient, the physician, and the insuring agency. If we determine the interests, the rights, and the responsibilities of each of these three principals we should be able to determine the type of plan which will best answer the better interests of all concerned. I do not feel that it is possible under any circumstances to create a plan which will satisfy all the desires of the principals. It is my feeling that the medically sponsored Service Benefit Plan of Blue Shield approaches most closely the optimum which we desire.

THE MEMBER-PATIENT

What are the interests of the member-patient in the problem? He, of course, wants to obtain the best medical care available for the particular difficulty in which he finds himself. He wishes to be able to have the cost of such care met by an insuring agency. He wishes to utilize the insurance principle because only by the application of that principle can he expect to have large and financially-disastrous

medical bills paid for him, and yet require but a modest prepayment membership charge from himself. In short, like all of us, he wants the most he can get for his money.

Despite some of the advance thinking of the past twenty years, most of us accept the fact that insuring companies no more than any other self-sustaining corporation do not create wealth. They can disburse in benefits only such monies as are received as premium income. The circumstance clearly defines, therefore, the limits to the benefits which the member may expect from an indemnity insurance corporation. He can receive in benefits his proper portion of the money which he and his fellow policy holders have paid into the fund. It is a simple cause and effect relationship.

As the costs of medical care have increased it is obvious that the premium charges necessary to make higher payments have also increased. Better health education information has become available to the people and remedial surgery, long overdue for many, has been made possible through the mechanisms of prepaid voluntary insurance. This increased incidence of surgery, certainly most worthwhile and beneficial, has nevertheless increased disbursements by the insurer and, therefore, increased the premiums to the policy holder. The member-patient is interested in having the advantage of all new developments in medicine, but it is improbable that he can have these services if he must meet the increased premium cost necessary for sound underwriting. The element of control is missing.

One solution to his dilemma is provided by the service benefit concept. Under service benefits the physician, otherwise not a party to the medical care insurance held by his patient, becomes directly concerned in it. I would like to note in passing that I think the term service benefits is a particularly poor title for the concept which it represents. Each of the words, service and benefits, have so many other common implications in reference to both professional and insurance matters that it seems difficult to me to create the proper recognition of this concept in the public mind by using the term service benefits. It would seem much more desirable that a term such as Blue Shield benefits or some similar nonconfusing title be applied to them provided, of course, that Blue Shield Benefits, as a title, always indicated that the coverage was on the basis which we now term service benefits.

THE PHYSICIAN

The basic principle of service benefits is that an individual will be insured against a particular type of medical or surgical care which he may require and that by being so insured will receive the necessary professional services from the physician of his choice without payment to the participating physician. The physician is paid by the insuring plan. It is obvious from this definition of the service benefit principle that the physician who agrees to render service benefits is obligating himself to accept a fixed fee for a particular type of service. The fee which he agrees to accept must be considered an "average" one for there is no means of determining in advance the degree of complexity which will confront the physician at the time the service is rendered. It is also manifestly impossible to determine, on an equitable basis, the relative severity of identical operative situations with different patients and different surgeons.

Service benefits, therefore, represent the physician's guarantee to the patient that if he should require a particular service it will be rendered him without additional charge by the physician regardless of the severity of the condition at the time of operation.

Service benefits seem to me to be the natural development of the ideals and traditions of the medical profession when the profession becomes a part of plans to insure individuals against the cost of their medical care. In fact, I do not see what other course of development was possible in keeping with medical traditions.

It has always been understood by both patient and physician that doctors of medicine assume the obligation of providing necessary medical care with no reference to, or prior determination of, the ability of the patient to pay. While this idealistic principle has been somewhat qualified by the materialism of our times and the physician's own problem of providing adequately for himself and his family during his relatively short years of high professional earnings, it still remains the guide by which medicine is practiced by the vast majority of physicians.

On this basis it does not seem proper to me for a physician to enter into the support and underwriting of a medical care plan with the idea that the plan payments would defray, only in part, the cost of his services to the low income patient. By so doing he is in effect guaranteeing payment to himself and also leaving himself free to make additional charge to the

patient. I cannot recall any previous situation in medicine wherein physicians were party to arrangements which benefited themselves more than their patients. Thus, to me the Blue Shield Indemnity Plan fails to measure up to the standards of the medical profession.

The majority of physicians, however, are in sympathy with Blue Shield programs. The unfailing support which the physicians of Connecticut, over 85 per cent of all those in practice, have given to Connecticut Medical Service is practical proof that they established CMS as a service benefit program with a clear intent to help their patients, not to complicate their medical care problem. The income level for service benefits in Connecticut in a brief five years has moved from \$3,500 to \$5,000 for a family. Participating physicians have not failed in any one of the five years to provide service benefits in half of the claims which have been paid. In addition, during the past two years some 11 per cent of claims each year were accepted by the participating physicians without further charge to the patient, even though the income of the member did not entitle him to service benefits. These practical evidences of conformity to the spirit as well as the letter of the service benefit contract between CMS and its members reflect the best traditions of medicine.

In becoming participating physicians in a service benefit program the doctor is called upon to make significant commitments. It should be helpful at this point to clarify the basic differences between service benefits which are provided by Blue Cross plans and those provided by Blue Shield plans. The important difference in these two situations has received very little attention, at least to my knowledge. Yet I believe it is the most important reason why Blue Cross plans find it relatively easy to provide their members service benefit contracts, when some Blue Shield plans have thus far found it impossible to do.

Normal Blue Cross operations are based on operating agreements between Blue Cross corporation and member hospitals. When satisfactory arrangements have been made the Blue Cross plan sells its contract to the members. From that point on, however, almost the entire functioning of the contract is between the member hospital and Blue Cross. In most cases the member simply shows his identification card to the admitting office of the hospital and has no concern about the hospital bill, except for services which may not be included in the coverage. Service benefits, therefore, under a Blue Cross semi-

private hospitalization program are the result of negotiations between a Blue Cross corporation and the hospital corporation.

Blue Shield service benefits, which result from agreements between participating physicians and the Blue Shield corporation, become available to the member only on a very personal basis. On the member's side it involves the statement of his annual income. On the participating physician's side it involves not only the acceptance of the member's income statement as reliable, but also his willingness to surrender his right to set his own fee, as has been mentioned earlier.

It is one thing for service benefits to accrue to a patient because two corporations are able to agree on mutually satisfactory financial arrangements. It is quite a different thing for an individual—the participating physician—to agree to forego a portion of his income which heretofore had been accepted as properly his.

Blue Cross service benefits do not exert any effect upon the incomes of the individuals operating the corporations who provide them; Blue Shield service benefits very definitely affect the incomes of the physicians who provide them on behalf of the Blue Shield corporation.

One of the few pleasures we are able to enjoy in this life without restraint, if we are in a position to do so, is to spend other peoples' money; witness the unqualified success of the expense account. Many people are convinced that the doctor should provide service benefits—patients, insurance companies, industrialists, labor and even executives like myself. But so far few, if any, have indicated any willingness to make a similar contribution from their own income to further the solution of the medical care problem.

Service benefits are a matter of very personal concern of the participating physician. He is relinquishing his right to evaluate his own services. He is entrusting the financial future of his practice to the decisions of the corporation in the arrangement of its fee schedule and its professional policies and, most important of all, he knows that having surrendered these important considerations, he will not regain them. He knows that the economics of medicine in the future will require more and more that he accept a specified fee for a particular service regardless of its complexity. The fee will be average because the mechanics of fee schedule construction

and the requirements of sound underwriting do not permit the variations in fee development which are possible in individual practice.

In many cases the fee which he receives will be small compensation indeed for the professional service he has rendered. It is also true that in some cases he will be over compensated for a case which is not a significant medical problem.

There is a great danger, however, in assuming that because the mechanics of prepaid medical plan operation require that we deal in average fees we discharge completely our obligation to the physician when we pay them. It is true that a service has been bought and paid for. But, in so thinking we neglect entirely the critical fact that all medical services are completely human relationships, that the physician who renders the service and the patient who requires the service are individuals extremely concerned about the restoration of the patient's health. The practice of medicine bears no relationship to the construction of a product or the rendering of trade services to inanimate objects.

I am not trying to persuade you that every visit to a physician is an adventure in lifesaving, nor that without the care of the physician the patient would not recover. The critical problems of human illness, however, (and these are the only aspects of medical care that should be covered by insurance) not only call upon the reserves of training and experience of the doctor of medicine, but also create for him a moral responsibility not merely to provide the indicated treatment but to exert every possible influence to effect the recovery of his patient.

We can readily pay for the technical performance of a particular operation or medical therapeutics. There is no possible means by which we may pay for a correct diagnosis, and yet without the latter the former is of doubtful importance. The service benefit patient receives a great deal more than is indicated by the "paid-in-full" stamp on his doctor's bill.

THE INSURING AGENCY

What are the interests of the physician in the situation when the patient's benefits are on an indemnity basis? He has no reason to be concerned with the operation of the indemnity insurance industry. He is paid for whatever services he renders which are provided by the insurance contract, according to a schedule of fees. His relations with the commercial insuring carrier are no different than

would be those of a repair garage in providing services under auto liability insurance.

The physician is not a party to the contracts entered into between the underwriting organization and the patient. He has no responsibility for the underwriting of the contracts under which he is paid. Further, and most important, he has no part in the arrangement of the fee schedules or the establishment of the policies which will govern the payment for his professional services. In rendering professional services, for which he will receive payment from a commercial indemnity insurance plan, the physician assumes no responsibility to his patient beyond that which governs the practice of medicine under the local statutes.

These circumstances obtain regardless of whether the indemnity insurance is provided by a carrier of the insurance industry, a fraternal, business, trade organization, or in most cases by a Blue Shield indemnity plan. It is clear then, there is no necessity for intervention by the physician in the insurance industry if the patient's benefits are to be on an indemnity basis.

The situation becomes quite different when the insuring plan provides service benefits. The service benefit concept requires that the participating physician assume his responsibilities far beyond what are required of him in his detached relationship to indemnity, medical-care insurance. As a participating physician he becomes, himself a sponsor, a contracting party, and a co-insurer of the medical care coverage which is written by his plan; in short, he enters the field of insurance.

The tremendous growth of Blue Shield medical care plans, all of which are sponsored by organized medical societies, indicates that physicians are now extensively involved in the field of medical care insurance. Properly, however, it is only in those Blue Shield plans which provide service benefits that the physician should be so involved.

Why has the physician found it necessary to participate in the sponsorship, the underwriting, and the rendering of services for the insuring corporation which he has established?

The question is a familiar one and arises in nearly every discussion involving Blue Shield coverage, not only from representatives of commercial insurance carriers, but frequently from labor or management during competitive sales promotion. The question does not seem to me to be as difficult to answer as

the frequency with which it is raised would indicate. If the physician is to guarantee as he does in providing service benefits, that he will accept the fee of the plan for the particular type of medical or surgical care which he renders, he certainly is entitled to be consulted in arrangement of such a fee schedule. He is also entitled to determine the policies which will govern the payment of the established fees. In many cases this consideration is far more important than the actual cash amount of the stated fee. He is also entitled to participate in the adjudication of problems which would arise between the patient-member, the plan, and himself.

Since commercial insurance carriers are unwilling that physicians should exercise these rights under commercial contracts there is no alternative, if service benefits are to be provided, but that the physician establish his own insuring corporation. Every commercial indemnity insurance carrier would like to have the physician provide service benefits to its members. Obviously it would be very helpful to their situation if doctors would agree to accept a flat fee as a total payment, and leave the determination of the amount of such a fee or how and when it would be paid to the discretion of the insurance carrier. Practicing physicians are not accustomed to signing such a blank check.

Some commercial insurance carriers have urged that organized medical units provide the fee schedule for areawide service benefits and then let the commercial company operate the insurance; they hold that there is no need for organized medicine to sponsor nonprofit service benefit medical care plans in competition with commercial insurance.

How long do you believe the service benefit fee schedule and its payment policies would be properly arranged to deal fairly with the practicing physician once the competition of a medically sponsored prepaid plan was no longer in existence?

There are ways in which areas of cooperation can be developed between the insurance industry and Service Benefit Blue Shield Plans. But the industry as yet has not indicated any willingness to meet with the medical profession except on terms which are quite unsatisfactory to the practicing physician. Eventually an equitable relationship may be developed between commercial insurance and practicing physicians who have already demonstrated their willingness to render service benefits. In any case, as long as practicing physicians are willing to render

service benefits they must be in a position to determine the fee schedules and the professional policies under which their services will be provided.

We have gone to some lengths in describing the relationship between the participating physician and the service benefit plan. What are the relations between the nonparticipating physician and the service plan?

THE NONPARTICIPATING PHYSICIAN

Opinions seem to vary widely as to the position which should be taken by a Service Benefit Blue Shield Plan in its relations with nonparticipating physicians. The actual practice differs from plans which completely ignore the nonparticipating physician even to the extent of not paying for services which he renders, to plans which seem to tolerate his status, and finally plans which treat him on the same basis as the participating physician.

While I am usually not one to suggest compromising a situation, I believe that in this particular matter the middle ground is the only logical one.

Plans which totally ignore the nonparticipating physician and do not pay for his services seem to me to interfere with the free choice of physicians by their members. They also do not harm the nonparticipating physician nearly as much as they harm their own members by not paying for services which the members presumably required. In addition, they inject an element of compulsion into participation which must be regarded as inconsistent with the voluntary nature of the entire nonprofit, prepaid medical care plans.

On the other hand, plans which treat both participating physicians and nonparticipating physicians alike, I believe, are unfair to the participating physician. Most participating agreements which are signed by the physician contain a clause which obligates the doctor to accept any proration of the stated fee which may be necessary to insure the financial stability of the corporation. This in fact makes each participating physician under such an agreement a co-insurer or at least a co-underwriter with the corporation. Such provisions in participating agreements are extremely important and in many cases that provision alone has been accepted by insurance commissioners at the time the plan was established, in lieu of substantial financial backing, as a safeguard that the plan would be able to deliver the services sold. In the case of Connecticut, our plan which now numbers 850,000 members was permitted to sell

its contract with a net capital of only \$10,000 plus the signed agreements of 1,534 participating physicians.

Since these physicians assume this significant responsibility it seems to me that some aspect of their relations with the Blue Shield Plan should be more favorable to them than it is to their nonparticipating associates who are unwilling to assume such responsibility. I do not believe it is necessary to penalize the nonparticipating physician (or more properly, his patient) by differential payments from those which are made to participating physicians. Neither do I think it is necessary for the plan to refer to nonparticipating physicians in a derogatory manner.

The middle course which we have chosen seems to me to represent a proper relationship between a service benefit plan and the nonparticipating physicians within our State. We pay identical cash amounts for all services rendered under our contract, whether the services are rendered by a participating or nonparticipating physician. In the matter of payments, however, we provide a distinct benefit to the participating physician. We pay him directly and promptly. We advise the member at the same time of the amount of payment and whether or not it has been made on a service benefit basis. For the services of nonparticipating physicians we pay the patient directly. This seems in order for us because in each case we are paying a party which has a contract with the corporation. Since the nonparticipating physician is unwilling to sign such a contract we do not feel that we have the obligation of giving him the benefit of direct payment. This is the only aspect of our relations with nonparticipating physicians which varies from those with participating physicians. Our monthly *Physician's Bulletin* is sent to all licensed physicians, and we adjudicate claims on behalf of members and participating physicians, or the member who has had the services of a nonparticipating physician. We believe that any step to make physicians become participants against their will is misdirected. We cannot hope to achieve further progress with the voluntary program when so important an element of such a program as participation by the physician is subject to compulsion, either obvious or implied.

Despite all the statements which I have made regarding fairness to nonparticipating physicians, I believe that by failing to participate they get a free ride at the expense of their participating colleagues.

I think it is important, however, to remind ourselves that we can hardly expect physicians to participate in Blue Shield plans and agree to render service benefits when the fee schedule and the entire program of the plan is inadequate for the needs of the local situation.

ADMINISTRATION OF SERVICE BENEFIT AND INDEMNITY PLANS

I cannot properly make any comparisons as to the difficulty of administration between service benefit and indemnity plans. It would seem obvious that service benefit plan administration is much more complicated than is indemnity operation. We have never felt, however, that the operation of a service benefit plan was so complex that it was not worth the undertaking. When the participating physician is willing to make the significant contribution of service benefits to his patient we should be willing and able to satisfactorily administer a corporation to make these benefits available to the people.

I think it is important that we clearly understand that nonprofit medical care plans, and even the Blue Shield organization itself, are only mechanisms to the end of providing prepaid medical care for the American people. The plans do not exist for themselves, but for the service which they may render to their members. There are many aspects of Blue Shield plans which distinguish them from the insurance industry and not least of these differences is the matter of the purposes for which they operate. Commercial insurance, and I do not disparage it in the least, is a business enterprise which looks toward expansion of its activities and the resultant increased profits for its stockholders. The Blue Shield plan, on the other hand, has only the incentive to increase its benefits and be of greater service to its members. Both the insurance industry and Blue Shield, therefore, work toward the common purpose of providing medical care from two different approaches. There should be no quarrel between Blue Shield

and the insurance industry, for within the limits for which the commercial carrier was established they are making excellent progress toward a solution of the cost-of-medical-care problem. In the same manner, Blue Shield which is not fettered with similar limitations has made substantially better progress.

VALUE OF SERVICE BENEFIT PLAN

Perhaps the greatest single obstacle to the future development of Blue Shield Medical Care Plans, in my opinion, lies in the fact that Blue Shield as a title does not yet mean service benefits. While there are some basic differences, chiefly in regard to profit making, which distinguish indemnity plans of Blue Shield from the indemnity plans of commercial carriers, they are not significantly beneficial to the member-patient. As far as the patient's obligation to pay for his medical care is concerned, it is immaterial whether he is covered under a commercial insurance indemnity contract or under a Blue Shield indemnity contract.

Some have felt that there is no necessity for all Blue Shield Plans to render service benefits and that the Blue Shield indemnity plan has just as much justification for operation as have the Blue Shield service benefit plans. I do not believe this to be so. The significant sponsorship by organized medicine which all Blue Shield plans (and they alone) have, precludes in my opinion their operation as competitive indemnity insurance carriers. I do not know of any benefits which a Blue Shield indemnity plan can provide its members that cannot be provided equally well or better by a commercial insurance indemnity contract. Blue Shield must mean service benefits or it must eventually fail to accomplish the purposes for which it was established.

Blue Shield cannot do its job unless it can guarantee service benefits to every eligible member. Service benefit income levels must be realistic and the provisions of the contracts must be practical.

Service benefit are all that Blue Shield has to sell.

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

Happy New Year! There's always hope, there's promise!
 No sorrow ever held a crocus back.
 The rigid earth revives, day breaks; tomorrow,
 Deliberate, comes down the starry track.

Driscoll

The World Medical Association

Unless one has had the privilege of attending sessions of the World Medical Association it is difficult to get a true perspective of just what this organization is accomplishing. In the first place it is the only medical organization that can speak on a voluntary basis at an international level on medical affairs. Each year the representatives from the various national medical groups come together in one of the constituent member countries, pool their experiences in all aspects of medical practice, and from these meeting of minds recommendations are made for the improvement of medical practice in the various parts of the world. It is not a policy making body.

The impressiveness of such a group may well be imagined. For example, the seventh annual general assembly met in that ancient and historic Knights Hall at The Hague, Netherlands. Such matters as cooperation with the International Medical Press, Social Security programs in Europe, the financial situation of physicians in India, the enthusiasm of Israeli doctors, the fusion of the Industrial Hygiene Division of International Labor Organization, and the Dutch system of certification, these and many more problems affecting medical practice were discussed.

Emanating from the activity of the World Medical Association came the first World Conference on Medical Education held in London in 1953. Out of this important gathering of representatives from more than 90 medical schools in 60 different countries arose much valuable discussion on the place of social and preventive medicine in the educational programs, the methods of student selection, the importance of cultural premedical training, and the overcrowding of medical schools in certain countries where medical education is a public and not a private enterprise.

The World Medical Association, although only eight years old, is growing rapidly and increasing its influence largely through the efforts of such individual supporters as our own Louis H. Bauer, Hugh Clegg of England, Paul Cibré of France, Dag Knutson of Sweden and S. C. Sen of India. Elsewhere in this issue appears a report from the American Medical Association Board of Trustees emphasizing the place of the World Medical Association and its claim on the physicians of America for support. We who practice medicine under the best conditions existing in the world today have an opportunity to assist our medical confreres in other countries by giving concrete evidence of our interest in world medical problems.

Group Therapy, Especially in Psychoneuroses

In 1905 Dr. Joseph H. Pratt of Boston conceived the idea of treating tuberculous patients in groups rather than as individuals. The method was so successful that it was subsequently adopted for use in other conditions which necessitated periodic supervision of those suffering from them, for example, undernourishment in childhood, diabetes mellitus, essential hypertension, dementia precox, alcoholism, and obesity. Group therapy was primarily set up as a result of the fact that the handling of single patients, especially in free dispensaries and in hospitals for mental disease, was so time consuming that it was far beyond the capacities of their regular staffs. Experience with the method, however, soon showed that a potent mental element entered into the situation, inasmuch as the method of conducting the sessions involves not merely instruction by the individual in charge of the group but also active participation on the part of the patients themselves. This adds enormously to the interest of the group members and is an outstanding factor in promoting recovery.

Any general practitioner or internist who has analyzed the nature of the diseases for which his patients consult him knows that roughly one-third of them, even after the most intensive clinical and technical examinations, present no conclusive evidence of organic ailments. While we have come to realize that patients with definite organic diseases frequently show psychic manifestations and may even need treatment for them, the fact that one out of every three sick people needs special mental training is immensely significant from a practical point of view. The element which makes mental training such a problem, particularly in institutions such as public dispensaries, is the time factor. If one practices psychotherapy along strictly Freudian lines, the amount of time involved in re-educating each patient is often enormous and the results are often dubious. Luckily it has been demonstrated that, while many of the Freudian principles have been of immense value, the method of their application can be simplified or, indeed, simpler methods such as those of DeJérine can be substituted.

Thirty years ago Dr. Pratt, influenced no doubt by the success of his tuberculosis program, decided to try the group technique in psychoneurotics. A

careful analysis of patients coming to the Medical Clinic at the Boston Dispensary had shown that in 36 per cent of them no evidence of organic disease could be found. The results of a twenty year period have been reviewed by bringing together the more important publications of those in charge of the actual work.* The class which Dr. Pratt started at the Boston Dispensary with three patients has grown steadily until the attendance now averages between forty and fifty at each session. No one can become a member until a thorough physical and technical appraisal has demonstrated an absence of evidence of organic disease.

The group, originally known as the class in "Thought Control," is now referred to as the class in applied psychology. The underlying principles governing the handling of the group are clearly explained in the introduction: an appreciation by the new patients gained by association and conference with the more experienced ones that they are not "peculiar," but that normal people suffer from like complaints; the opportunity offered each patient to circulate and ventilate his repressed fears through the doctor and fellow patients; the establishment of the feeling in each patient through a roll call, discussion of problems, friendly companionship and praise for progress, that he is receiving personal attention; the reports of progress presented by patients who have been under treatment for some time; a period of relaxing exercises at each session; emotional re-education; a technique by which patients progress step by step and enjoy the opportunity by association with others of gaining a working perspective.

An analysis of the twenty year results shows that from 60 to 90 per cent of the patients are helped to recovery. There is opportunity for those who make slow or unsatisfactory progress to be referred to special advisers or, if need be, to other services. There is also opportunity for medical students and professional health workers of various types to visit the group, a special section of the consulting room being set apart for them. One cannot fail to conclude, we think, that the plan as worked out by Dr. Pratt and his associates represents a strikingly successful solution of a difficult problem.

G. B.

*A Twenty Year Experiment in Group Therapy, edited by Joseph H. Pratt and Paul E. Johnson. The New England Medical Center, 25 Bennet Street, Boston, Massachusetts.

The Intern in 1955

With the differential of about 3,000 more vacancies than there are interns available to fill them, the internship problem continues to remain just that, viz., a problem. Like our neighbors in Rhode Island there are some who would throw out the window the matching plan now quite universally adopted in this country. On the whole, however, this plan seems to be working satisfactorily and is probably here to stay, at least as long as we have interns.

A special Ad Hoc Committee on Internships was recently appointed by the American Medical Association and made its final report at the Miami session of the House of Delegates. Out of this report have come some interesting observations. One of these relates to the approved internship training program in federal hospitals which, it had been said, existed only because the Dean's Committees desired them and not because of any preference expressed by the Veterans Administration. On investigation the special committee came up with the opinion that these programs in federal hospitals compare favorably with other approved programs and should not be discarded.

Another facet of the internship problem relates to graduates of foreign medical schools who now fill 23.2 per cent of the approved internships in the United States. Various requirements for this group have been set up in the different States. The committee believes that the medical licensure for this group should be under the jurisdiction of the governments of the various States and, more than that, that the governing board of each hospital should make its own decision as to whether or not graduates of foreign medical schools are acceptable as interns. The committee proposed three conditions which should be fulfilled by the foreign graduate before being considered for intern appointment in an approved hospital:

1. Language difficulties will not seriously impair the program;
2. The same educational standards are applied to graduates of foreign schools as to graduates of approved American medical colleges;
3. The appropriate State licensing board approves.

With the increasing emphasis on specialization there has been a tendency to regard the intern as a glorified clerk and much of his clinical experience has been pointed toward specialty training. Even

though there has been considerable effort made to orient the undergraduate and sometimes the intern through general practice outpatient clinics, preceptorships, home care programs and the like, yet there are still many medical schools and major affiliated hospitals which have not felt an equal responsibility in the field of general practice as they do in teaching the specialties. This all points to a greater emphasis on a broad training for the intern and the avoidance of assigning interns to subspecialties in any hospital. The committee recommended a properly organized rotating internship for all graduates of medical schools.

Those advocating adherence to the "two-thirds rule" will be interested to learn that had this remained a requirement and been rigidly applied to the two consecutive intern years 1952-3 in combination with 1953-4, it would have removed 448 hospitals, cancelled 4,205 internships to which 784 students were matched in those years and reduced the number of internships available to 6,766. The committee agrees that present standards in the accrediting program are too broad and unrealistic and for this reason objective study of each local situation is the only proper solution. It suggests disapproval for internship training of any program which in two successive years fails to obtain one-fourth of its stated intern complement. However, the application of any such requirement should be on an individual basis and subject to constant review and prompt revision.

This paragraph near the close of the committee's report warrants emphasis:

"There is reason for all hospital staffs that now conduct approved programs to institute a searching reappraisal of the general attitude of the medical staff. No definition and no set of standards for approval can insure the vital ingredient of staff enthusiasm. Only the medical staff knows which of its members are contributors and which are drones. There should be a fair, objective and firm determination of intern responsibility for private services. It follows that staff members who fail to assist the program must themselves provide adequate coverage."

As medical care grows more complex the place of the intern in this program loses none of its importance. Is he to be a mere medical clerk? Are we overemphasizing the specialties at this stage of medical training? Are we assuming the full responsibility

ities of a teaching program which our modern hospital makes possible? Whether the intern goes on to a residency or out into general practice his understanding of the traditional ideals of the medical profession may be developed during his internship. Of these ideals, service to the sick comes first.

The Honor of Serving

From Rhode Island Medical Journal

The privilege of serving as an officer of a State Medical Society is more than a mere honor. The work facing each new administration of a State Society annually takes on new and greater proportions, as any of our officers can attest. The strength of the success of this work lies in the cooperation of the House of Delegates, Council, and the many active committees. Last month the *Nebraska State Medical Journal* established a precedent in publishing a sharp editorial criticizing members of its House of Delegates for failing to attend meetings to shape the policies of the Association. At the annual session four county societies failed to send delegates, seventeen elected delegates failed to attend the session, and of the forty-seven delegates registered, only eighteen attended each of the four sessions of the House. Geographically, Nebraska is a very large State, but distance certainly should be no excuse for failing to represent a county society at an annual session, and the alternate delegate system should prevail to guarantee a full representation. In Rhode Island our House of Delegates meets three times a year, and the traveling is a minimum for nearly all the delegates. Even so, we too have had an occasion when a complete State-wide representation was not in attendance. The solution of this type of problem rests at the county or district level, where appointments or elections of councillors and delegates should guarantee that the choice will be of physicians who will promise to attend sessions and participate in the development of State-wide policies.

President Eisenhower Receives Lahey Memorial Award

President Eisenhower was the recipient in November of the Frank H. Lahey Memorial Award for his "outstanding leadership in medical education."

The three-and-a-half inch bronze medal, encased in a beautiful mahogany frame, was presented to

the President by S. Sloan Colt, New York, president of the National Fund for Medical Education. Witnessing the ceremony at the White House was President Walter B. Martin, representing the AMA, and representatives of two other organizations—the National Fund for Medical Education and the Association of American Medical Colleges.

This is the first time that this award has been given. The three organizations sponsored the award in memory of Dr. Lahey, who served as president of the AMA in 1941 and who worked untiringly to help the nation's medical schools financially and without government subsidy.

President Eisenhower was elected to receive the award because, as one of the founders of the National Fund for Medical Education, he recognized, as Mr. Colt said in bestowing the medal, "the importance of keeping medical education free, progressive and solvent so the medical schools could continue to nourish medical practice and research unhampered by curtailment of programs and uncompromised by government subsidy."

Medical Education Problems to be Aired at Congress

What part television can play in future postgraduate medical education will be one of the featured attractions of the 51st annual Congress on Medical Education and Licensure to be held February 5-8 at the Palmer House, Chicago. The meeting will be sponsored by the AMA's Council on Medical Education and Hospitals in cooperation with the Federation of State Medical Boards of the United States and the Advisory Board for Medical Specialties.

The first of a series of annual work-shop conferences in the field of postgraduate medical education will be devoted to the potential use of television during the all-day session February 5. Open meetings of the Advisory Board and the Federation will be held February 6.

Highlighting the place of legal and forensic medicine in undergraduate medical education and the future status of the internship in the medical education program will be discussed during the AMA Council's program February 7. The February 8 sessions will be conducted by the Federation.

More than 500 medical educators, officers and members of State licensing boards and others interested in postgraduate medical education are expected to attend the four-day conference.

THE PRESIDENT'S PAGE

NEW YEAR'S GREETING

At the dawning of this new year, physicians throughout our nation have much for which to be deeply grateful. Those in Connecticut live in one of the most beautiful and richly blessed regions of a country that is now at peace and at a high average level of prosperity. Physicians as individuals are respected and honored by their patients, even though the medical profession as a whole is being vigorously criticized for many alleged shortcomings. There is still complete freedom to engage in general practice or in any desired specialty, to practice alone or in a group, to do research or teaching, to derive one's income from fees or from salary. In this country, as in few others, the latest advances in diagnostic and therapeutic methods are made available almost immediately to all who will take time to read, watch, or listen. We are still largely free of governmental control. There are generations of inspiring tradition to encourage physicians to confer freely with one another about difficult problems and to ask unhesitatingly for help from those whose training and experience have qualified them to give it.

But most of all, I think we have cause to be profoundly thankful that we *are* physicians. What other group, except possibly those who minister to man's spiritual needs, has opportunities so exciting, so filled with promise and reward, so thrilling in their revelations of human frailty and strength, pettiness and nobility? There must be joy in all work that is creative, all that requires intelligence and imagination. But how much greater the joy if one's objective is to seek truth and apply it for the betterment of man's physical, mental, and emotional health. What greater privilege could there be than this: of devoting one's self to the service of troubled humanity; of bringing comfort and peace, courage and faith, to others in their hours of need?

High privilege inevitably involves responsibilities. If we accept and discharge these faithfully, the doctor will long keep his honored place in society. The day has passed when physicians could hold themselves aloof from civic, state, and national obligations; even those engaged in full-time teaching or research are learning the importance and value of playing a more active role in the social and political life of their communities.

Too often, I fear, the physician is so busy ministering to the physical needs of others that he loses sight of the essential nobility of his profession, and undervalues the comfort and joy that he can give through his knowledge and his presence. Perhaps I will be forgiven for recalling to your minds the known challenge that we accepted eagerly when we entered medicine. It makes stern demands upon all who would claim its sanctions; it has high standards to which we must conform if we would receive its blessings. But to those who serve with humility and devotion, with high hearts and willing hands, the rewards are beyond all telling.

On a Christmas eve more than 350 years ago Fra Giovanni wrote to his friend "The Most Illustrious, The Contessina Allagia della Aldobrandeschi" in eloquent words known to many who may rejoice at reading them again today:

"There is nothing I can give you which you have not got, but there is much, very much, that, while I cannot give it, you can take. No heaven can come to us unless our hearts find rest in it today. Take heaven! No peace lies in the future which is not hidden in this present little instant. Take peace! . . . Life is so generous a giver, but we, judging its gifts by their covering, cast them away as ugly or heavy or hard. Remove the covering, and you will find beneath it a living splendor, woven of love, by wisdom, with power. Welcome it, grasp it, and you touch the Angel's hand that brings it to you. Everything we call a trial, a sorrow, or a duty: believe me, that Angel's hand is there; the gift is there, and the wonder of an overshadowing presence . . . Life is so full of meaning and of purpose, so full of beauty beneath its covering, that you will find earth but cloaks your heaven. Courage, then, to claim it, that is all! But courage you have; and the knowledge that we are pilgrims together, wending, through unknown country, home."

I find much comfort and happiness in the thought that we too are pilgrims together, sharing a common faith, inspired by the same noble purpose. To all who have embarked upon this pilgrimage I send a word of New Year's greeting to express pride and joy in your accomplishments and the hope that this year will be wonderfully rich in emotional satisfactions.

H. M. Marvin, M.D.

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SEMI-ANNUAL MEETING OF HOUSE OF DELEGATES

The Semi-Annual Meeting of the House of Delegates was held in New Haven Medical Association, Thursday, December 9, 1954. The meeting was called to order at four o'clock by the Speaker, Cole B. Gibson, and three reference committees were appointed.

REPORT OF THE PRESIDENT

The report of the president was presented in which he emphasized the importance of the painstaking and serious work accomplished at monthly meetings of the Council, his visits to the County Medical Associations at their semi-annual meetings in October, and drew particular attention to the desirability of the Society extending its contributions to the American Medical Education Foundation.

REPORT OF THE SECRETARY

The executive secretary reported membership in the Society was at an all time high, totalling 3,018, the first time 3,000 had been exceeded. There had been a net gain of 155 members during 1954 which is perhaps the largest gain in any single year. The secretaries of the county associations were complimented for their diligent and consistent efforts to obtain new members. The discrepancy between the number of members in good standing in the Society and the number paying dues to the American Medical Association was pointed out, there being somewhat over 300 members of the Society who are not members of the American Medical Association.

BUDGET AND DUES FOR 1955

The treasurer presented the budget for 1955 in detail, explaining proposed expansion in some of the Society's activities. The budget as approved by the Council totaled \$107,090.32 and dues of \$28 for 1955 were recommended. This is an increase of \$3 in dues that have prevailed since 1948. A motion was made and seconded to increase the recommended dues from \$28 to \$30 so that student loan fund could

be established and leave the planning of this fund to the Council and not include it definitely in the 1955 budget. The motion was lost by a narrow margin and the budget as proposed by the Council and dues of \$28 were unanimously approved. This figure compares with other New England States: Maine \$35; Massachusetts \$35; New Hampshire \$40; Rhode Island \$50; Vermont \$35.

1955 APPROPRIATION FOR AMERICAN MEDICAL EDUCATION FOUNDATION

It was voted that the recommendation of the Council that the Society appropriate \$1,000 from its surplus funds for the American Medical Education Foundation in 1955 be approved.

AMENDMENTS TO THE BY-LAWS

Several changes of the By-Laws recommended by the Council were accepted. The purpose of these is to make the Speaker and Vice-Speaker of the House and Alternate Councilors full voting members of the Council. Alternate Councilors are to be elected for two-year terms in the same year and the same manner as Councilors are now elected.

AMA HOUSE OF DELEGATES MIAMI MEETING

Thomas J. Danaher, delegate to the American Medical Association House of Delegates reported in detail concerning actions taken in the meeting of the House held in Miami, November 29 - December 2.

SCHOLARSHIP AWARDS

President H. M. Marvin reporting for the Scholarship Award Committee stated that the five medical school scholarships for 1954 will be awarded to: Edward D. Coppola, Waterford, Connecticut, senior

student in the Yale University School of Medicine; Robert A. Goyer, Collinsville, Connecticut, senior student in St. Louis University School of Medicine; Daniel J. Lion, New Haven, Connecticut, senior student State University of New York College of Medicine at New York City; Arthur J. McPadden, Jr., Bridgeport, Connecticut, senior student at University of Vermont College of Medicine and William Vounatso, Hartford, Connecticut, senior student at University of Pennsylvania School of Medicine.

A RESOLUTION CONCERNING MEDICAL EDUCATION

The Society's Committee for the American Medical Education Foundation presented the following resolution:

WHEREAS high standards of medical care require high standards of medical education, and

WHEREAS America's physicians have constantly striven through their medical associations to elevate standards of medical education, with the result that today the 80 approved medical schools in the United States offer physician training unparalleled in quality, and

WHEREAS our medical schools conduct modern research programs which have signalled many victories on the frontiers of disease, and

WHEREAS these institutions of learning have trained America's physicians in peace and war and have been called upon in many areas to train dental, pharmacy, nursing and technical students and to conduct postgraduate medical courses, and

WHEREAS a financial crisis now threatens the schools and endangers medical progress as we face the challenge of a new era, and

WHEREAS the annual fund raising campaigns of the American Medical Education Foundation and the National Fund for Medical Education have become major factors in helping our medical schools meet their financial requirements and maintain high educational standards.

BE IT THEREFORE RESOLVED that this House of Delegates record its endorsement and its appreciation of the notable accomplishments of these two great organizations and their growing list of donors, comprising physicians, business corporations, private citizens, professional groups, and the Woman's Auxiliaries to medical associations.

BE IT FURTHER RESOLVED that physicians be urged to continue giving annually to this important cause in full faith.

This resolution was referred to a Reference Committee consisting of Walter I. Russell, chairman, Norman H. Gardner and Edwin F. Trautman. Later the Reference Committee reported recommending the adoption of the resolution with a minor amendment made by the committee. It was unanimously voted to adopt the resolution.

A RESOLUTION CONCERNING SUPERVISION OF HOSPITAL LABORATORIES

The Connecticut Society of Pathology submitted the following resolution:

WHEREAS, it has been proposed in some areas that certain portions of the medical specialty of pathology are not the practice of medicine and that laboratory procedures usually performed by medical technologists are technical and not medical functions and this work could legitimately be carried on under the direct control of the hospital, and

WHEREAS, the Connecticut Society of Pathology opposes this point of view and wishes to record its support to the position that all of pathology, including the clinical laboratory procedures in question, is in fact the practice of medicine and that professional medical supervision is essential to the proper conduct of a clinical laboratory, and

WHEREAS, the selection of tests to be employed in a clinical laboratory, the training of medical technologists, the supervision of the technical performance of laboratory tests, and their interpretation and evaluation requires a broad medical background and specialized training, and

WHEREAS, most laboratory procedures can on occasion lead directly to medical diagnosis, and medical diagnosis is considered a part of medical practice

BE IT RESOLVED, that the direct control of part of of a laboratory by the hospital could deprive the laboratory of proper medical supervision, and, would be inconsonant with good medical practice and contrary to the interests of patients.

This resolution was referred to a Reference Committee consisting of Ralph T. Ogden, chairman; William H. Curley, Jr., and William E. Hall. After its hearings the Reference Committee recommended the adoption of the resolution without change. It was unanimously voted to adopt the resolution.

A RESOLUTION CONCERNING CHRONIC DISEASE PROGRAM IN THE STATE DEPARTMENT OF HEALTH

The Committee on Public Health submitted the following resolution:

WEREAS chronic diseases are a problem of continued concern to the physicians of Connecticut; and

WHEREAS prevention and control of chronic diseases represent logical means of alleviating human suffering; and

WHEREAS a program for the prevention and control of chronic diseases proposed by the Connecticut State Department of Health has been under continued review since November 1948, and has received periodic endorsement by the Public Health Committee of the Connecticut State Medical Society: Therefore be it

RESOLVED, that the House of Delegates of the Connecticut State Medical Society express its approval in principle of the program for the prevention and control of chronic disease as reviewed at the November 1954 meeting of the Public Health Committee of this Society, and as contained in the budget request of the Connecticut State Department of Health; and furthermore be it

RESOLVED, that the Governor-elect of the State of Connecticut, The Honorable Abraham A. Ribicoff, be apprised of this action of the House of Delegates.

This resolution was referred to a Reference Committee consisting of Thomas M. Feeney, chairman; Edwin R. Connors, and Christopher E. Dwyer. This committee heard a number of members of the House who wished to speak on the resolution and after its deliberation reported to the House recommending that the resolution be referred to the Council for action at the earliest possible time. This recommendation was debated at length, but was finally passed by a split vote and the resolution was referred to the Council.

PRESENTATION OF A CITATION FOR OUTSTANDING SERVICE
FROM PRESIDENT'S COMMITTEE FOR THE EMPLOYMENT OF THE PHYSICALLY HANDICAPPED

The Citation for Outstanding Service from the President's Committee for the Employment of the Physically Handicapped was presented to Thomas F. Hines, New Haven by Mr. Edward P. Chester, member of the Connecticut Committee and director of rehabilitation of the State Department of Education. The award was accepted by Dr. Hines.

INTERIM REPORT FROM THE SPECIAL COMMITTEE ON
THIRD PARTY PAYMENTS FOR MEDICAL AND ANCILLARY NONSURGICAL SERVICES

By unanimous vote of the House, Benjamin V. White, chairman of the special Committee on Third

Party Payments for Medical and Ancillary Non-Surgical Services, authorized by the House of Delegates at its Annual Meeting on April 27, 1954 was given the privilege of presenting the following Interim Report which contains certain recommendations relating to the policies of the committee:

In accordance with a resolution adopted by the House of Delegates at its Annual Meeting on April 27, 1954, the president of each county society appointed two men representing the "various non-surgical components of medicine to explore the whole matter of fair remuneration for medical and ancillary non-surgical services." At the organization meeting on July 15, 1954, Dr. Benjamin V. White of Hartford was elected chairman and Dr. Joseph J. Bowen of Waterbury, recorder. The Committee as a whole has held five meetings, and a subcommittee has discussed mutual problems with representatives of CMS. At the present time a joint meeting of this Committee with the entire Professional Policy Committee of CMS is being arranged, and a documented report will be prepared for presentation to the House of Delegates at its annual meeting in April, 1955.

From the outset there has been confusion on the part of the members of this Committee and on the part of the Council as to the manner in which reports should be submitted. The original resolution introduced into the House of Delegates last April called for a committee appointed by the Council which would report to the Council. The original resolution, as amended by a reference committee and adopted by the House of Delegates, reads in part as follows:

"Each county society appoint two men representing the various non-surgical components of medicine to explore the whole matter of fair remuneration for medical and ancillary non-surgical services, with the idea of preparing policies and fee tables for guidance in dealing with third party payments, whether offered by CMS, private insurers or state welfare agencies, such group to elect its own chairman, and present its findings to the Professional Policy Committee of Connecticut Medical Service for its consideration."

The present Committee was, therefore, apparently authorized to consult with the Professional Policy Committee of CMS but no provision was made for reporting back to the House of Delegates.

Your Committee believes that this confused situation can best be resolved by the following interpretation:

tation of the intent of the House of Delegates which is recommended for adoption:

- 1. That the Committee on Third Party Payments for Medical and Ancillary Nonsurgical Services, having been brought into being by the House of Delegates, shall report to the House of Delegates.
- 2. That the Committee is authorized to deal directly with the Professional Policy Committee of CMS in the exploratory phases of its work.
- 3. That this Committee, when practicable, shall as a courtesy submit its reports through the Council, which shall have the right to include its recommendations on any of the provisions.

The report and recommendations were unanimously adopted.

DR. MURDOCK RECOGNIZED

Thomas P. Murdock, Meriden, past president of the Society and trustee of the American Medical Association, was called upon for remarks and he outlined briefly certain present activities of the Board of Trustees of the AMA.

Meeting adjourned for buffet supper at seven o'clock.

Dr. Booth Reappointed

Governor John Lodge has reappointed John D. Booth, Danbury to be a member of the Connecticut Medical Examining Board for a term of five years commencing January 1, 1955. Dr. Booth became a member of the Board September 26, 1946 succeeding Daniel C. Patterson, deceased, and has served as president of the Board since the retirement of Thomas P. Murdock. He is also a representative of the Board in the Federation of State Medical Examining Boards of the United States.

Meetings Held in December

- December 1—Committee to Study Maternal Mortality and Morbidity
- December 2—Committee on Public Relations
Subcommittee on Toxemia
Special Committee on Third Party Payments for Medical and Ancillary Nonsurgical Services
- December 7—Scholarship Award Committee
- December 8—Committee on Neonatal Mortality
Advisory Committee to the State Welfare Department

- December 8—Fellowship Committee—Connecticut Cancer Society
Board of Directors—CMS
- December 9—House of Delegates
- December 13—Cornell Crash Injury Research Conference
- December 14—Conference Committee with Connecticut State Dental Association
- December 15—Committee on Hospitals
- December 16—Council
Subcommittee on School Health

New Nonexplosive Anesthetic

John H. Lawrence of the University of California has reported to the Joint Congressional Committee on Atomic Energy that a combination of 80 per cent xenon and 20 per cent oxygen has been used as an effective nonexplosive anesthetic during major surgery. The heavy gas xenon, companion of helium, neon, argon, and krypton and the rarest element in the atmosphere, heretofore has been supposed to be inert. The discovery came accidentally during experiments on the medicinal effects of various isotopes at the University of Iowa's Laboratory of Medicinal Physics. Doctors observed that subjects exposed to xenon became drowsy. This led to experiments with rats and mice which showed that they could be anesthetized.

THE DOCTOR'S OFFICE


Patrick N. Brown, M.D. announces the opening of an office for the practice of dermatology at 133 Main Street, Bristol.

Paul V. Leone, M.D. announces the opening of an office for the practice of obstetrics and gynecology at 96 Coleman Street, Bridgeport.

Frank J. Leo, M.D. announces the opening of an office for the practice of obstetrics and gynecology at 28 Terry Road, East Hartford.

James Loftus, M.D. announces his return to the practice of obstetrics and gynecology at 350 Farmington Avenue, Hartford.

Harold Gregory Plakins, M.D. announces the opening of an office for the general practice of medicine and surgery at 155 North Main Street, Wallingford.



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THE HISTORIAN'S NOTE BOOK

PREPAYMENT MEDICAL CARE IN THE 17th CENTURY

WE are indebted to Dr. A. D. Kelly, deputy general secretary of The Canadian Medical Association, for bringing to light two instances of pre-paid medical care plans on this continent in the latter half of the 17th century. It will be evident from these two documents that the desires of patients to provide themselves with the means of budgeting against the cost of illness is no new development. The first represents a valid contract in the field of health insurance with specific coverage, definite conclusions, an insurable group, broad benefits and provision for termination. It will be noted that there is no freedom of choice of physician. The colony of Ville Marie had been established only thirteen years earlier and probably boasted very few practitioners of medicine.

Here is the document translated from the original French as preserved in the Archives of the City of Montreal:

"March 3rd, 1655

"Before us, the undersigned, Lambert de Closse, clerk and tabellion of Ville Marie on the Island of Montreal,

"Were present in person; Urbain Tessier called La Vigne, Louis Guereatin, Nicholas Millet, Gilbert Barbier, and thirty-two others, acting both for themselves and their families and children, of the one part, and

"Estienne Bouchard, master surgeon of the said Ville Marie of the other part,

"Who, in the presence of the Governor of the said Island have come to the following agreement, namely the said Bouchard undertakes and obliges himself to dress and to physic for all sorts of illness, whether natural or accidental except the plague, smallpox, leprosy, epilepsy and lithotomy or cutting for the stone, until a complete recovery or as com-

plete as may be possible, in consideration of the sum of one hundred sols† each year for each of the above mentioned persons and for their wives and children, payable in two terms and quarters, the period to begin to run today. And for their children who may hereafter be born, from the day of their birth, and, in the event of the death of any one of the above mentioned, the said Bouchard shall nevertheless be paid for the full year no matter in what season or day such death should take place. Moreover the said Bouchard shall be at liberty as shall be the other parties hereto, to cancel the present agreement at any time and at their discretion upon giving due notice to those concerned, such notice, however, to avail only for the years which have not begun to run, moreover the said Bouchard shall not be entitled to cancel the present agreement with respect to any persons who are suffering from any illness unless he has first cured them or unless such cancellation be with their consent.

"Done at the Fort of Ville Marie on the said Island on the third day of March, one thousand six hundred and fifty-five, where thirteen of the above mentioned have signed with the said Bouchard and the remainder declare themselves unable to sign.

"Paul de Chomedy
"L. Closse"

The second contract has elements in common with today's insurance contracts but it also reflects the hospital practices of that day. There is no reference to any system of honorary attending medical staff, but rather the Mother Superior undertook to see that her charges, who were charity patients, were adequately cared for by engaging too early rising physicians of the growing settlement of Ville de Montreal.

"August 20th, 1681.

"Before the undersigned notary, of the Island of Montreal in New France and the undersigned witnesses were present:

†A sol, according to historian Maude Abbott, is equivalent to one cent present currency.

"Reverend Mother Renee le Jumeau, superior of the Dames Religieuses Hospitalieres of this place, Sister Marie Morin, depository of the hospital of the one part, and

"Siours Jean Martinet de Fonblanche and Antoine Forestier, master surgeons, residing in this town, who have entered into the following agreement, namely;

"The said surgeons promise and oblige themselves well and truly to serve the Hospital of Ville Marie, to treat, dress, and physic all the sick persons who may be there, and this for periods of three months each in turn and to visit such sick persons assiduously at about seven o'clock each morning and at such other hours as may be necessary, and this for and in consideration of the sum of 75 livres[‡] each per year. To commence the time of their service from the first of July last, and upon condition that the said surgeons may not claim or seek to recover anything else whatever from the said patients nor from the boy who serves the said hospital, either for shaving or for any other reason.

"And they shall furnish only their own labor and effort, all remedies to be furnished by the hospital and moreover, the said surgeons promise and undertake to visit the said hospital, the one in the absence of the other when they may be so required.

"For in this manner promising, etc., obliging, etc., renouncing, etc.,

"Done and passed at the said hospital with the approbation of Messire Gabriel Souart, former priest of the Seminary of St. Sulpice of Paris, now residing in the Seminary of Montreal, their superior, and in the presence of Sieur Louis Marin Boucher Boissuison and of Pierre Maguet, witnesses their residing who with the said Dames Religieuses the surgeons and the undersigned notary and Sieur G. Souart, have signed August 20, 1681.

"G. Souart

"Soeur Renee le Jumeau

"Soeur Marie Morin

"A. Forestier

"J. Martinet

"Maguet

"Maguet, notary"

[‡]One livre was the equivalent of 20 sols, or 20 cents present currency.

Dr. Thoms Describes New Wonders of Conception

In an interesting article carried by the *Woman's Home Companion* (November, 1954) Herbert Thoms, professor emeritus of obstetrics and gynecology at Yale and former literary editor of the *JOURNAL*, tells the story of the process of conception in terms the laity can understand. The plethora of medical and health articles appearing in lay publications since the beginning of the present decade unfortunately has included many which have been scathingly critical of the medical profession, and unfair in their conclusions. Unlike these, Dr. Thoms' article is constructive, written in terms the uninitiated can understand and at the same time dealing with one of the complex processes in life, that of reproduction.

You may not think the average reader of the *Companion* wants to know anything about genes, chromosomes, sperms and human eggs but this is not true. The frustrated couple undergoing investigation for infertility is anxious to learn the why and the wherefore. Even the couple which has successfully reared a sizeable family scans the modern weeklies and monthlies for the latest in scientific achievement. We believe these stories when well written by experts are preferable for the public to those which throw mud, create false impressions by exposing the crooks, and in the end accomplish nothing.

Dr. Thoms has written well—he always writes well—and this latest product of his pen is to be highly recommended for your patients and anyone else interested in the "secrets of life's most miraculous moment."

Heart Association Grants

Local chapters of the Connecticut Heart Association have made research grants totaling \$33,355 for 17 research projects in Connecticut.

Connecticut's heart research program now involves 12 investigators working in six different institutions. Ten of the Connecticut Heart Association's 16 chapters are participating. Eight of the projects are being carried out in Yale-New Haven Medical Center, one is in the Hospital of St. Raphael, one in the Veterans Administration Hospital in West Haven, one in Bridgeport Hospital, one at the University of Connecticut, and one in Hartford Hospital.

Special Article

PRACTICE OF MEDICINE BY HOSPITALS

The Attorney General for the State of Connecticut, in response to an inquiry from the Connecticut Medical Examining Board has filed the following opinion on December 3, 1954.

This is in reply to your letter wherein you make the following inquiry:

"In those instances where hospital management employs physicians on full time salaries to render professional services, such as radiology, anesthesiology and pathology, and charge patients fees for the services of these employed physicians, the fees accruing to the benefit of the hospital, is it to be considered that these hospitals are engaged in the practice of medicine in a way that is in conflict with Connecticut law?"

As we understand your question, it is directed to the conduct of several of the general charitable hospitals in this State in employing licensed physicians at stated salaries and who devote their full time at the hospital. These physicians are experts in various fields of medicine; they use equipment and quarters furnished by the hospital and located in the hospital building for the purpose of conducting necessary tests, taking of x-rays and administering anesthesia for the benefit of patients in the hospital, those sent there by attending physicians, and emergency cases. The services are therefore limited to those persons who are actual or potential hospital patients and, generally, as an aid to the attending physician or to the hospital staff of interns and resident physicians. For the services of these full-time paid physicians and the use of the testing preparations, material and equipment, a separate charge is made to the patient on the hospital bill without separate itemization which, when paid, is kept by the hospital as part of its general income.

The question is whether these hospitals are violating the statute (Sec. 1660c, 1953 Sup.) concerning the right to practice medicine or surgery, the material portion of which reads as follows:

"No person shall, for compensation, gain or reward, received or expected, diagnose, treat, operate for or prescribe for any injury, deformity, ailment or

disease, actual or imaginary, of another person, nor practice surgery, until he shall have obtained such a certificate of registration as is in section 1661c provided, . . ."

Though not expressly stated in the statute, the implication is clear that the practice of medicine and surgery is restricted to individuals and does not include corporations (see 22 Op. Atty. Gen. 443; *McMurdo vs. Getter*, 298 Mass. 363, 10 N.E. 2d 139). However, the corporations excluded from practice, at least in this State, do not encompass non-profit charitable hospitals. The restriction is directed against the so-called commercial corporations which are run for profit. The obvious purpose of the licensing law is to protect the public from quacks and exploitation. These elements are not present in the service, care and treatment which a patient receives in a nonprofit, charitable hospital. (*Group Health Assn. vs. Moor*, 24 Fed. Sup. 445.)

The General Assembly has recognized the difference between a hospital and other corporation. Sec. 1545c, 1953 Sup., provides for the licensing of all hospitals, the material portion of which reads as follows:

"No person, firm or corporation shall operate a hospital for the care of the sick unless such person, firm or corporation shall have obtained a license therefor from the state department of health. . . . For the purpose of this section, a hospital is defined as an institution for the lodging, care and treatment of persons suffering from disease or abnormal physical conditions."

Since a hospital, by the foregoing definition, is a place for the "treatment of persons suffering from disease or abnormal physical conditions," it is clear that the legislature has created an exemption to the prohibitions contained in Sec. 1660c in favor of duly licensed hospitals. The only way a hospital corporation could "treat" patients is through its personnel who are licensed physicians. It is significant that a hospital is organized for the purpose of treating patients. In hiring licensed physicians to treat patients it is rendering the service for which it is

primarily organized. It has long been the accepted practice that interns and resident physicians treat patients in hospitals. Part of the hospital charge to the patient is for the services of such licensed personnel. No question has ever been raised that the hospital is practicing medicine illegally because it keeps the entire charge made for these services. No claim is being made that the various kinds of physicians involved in this controversy are not fully licensed and competent. The claim is that these individuals who unquestionably could act if they were not salaried employees of a hospital, are forbidden to act solely because they are on salary and the fee for their services is paid to the hospital rather than directly from patient to physician. We fail to see any distinction between this situation and the one involving the services of a resident physician who is on salary from the hospital, for whose services the hospital makes a charge in its general bill. (See *Right of Corporation to Practice Medicine*, 48 Y.L.J. 346.)

In considering the right of a hospital to treat patients under similar statutory conditions as exist in this State it has been said:

"Thus a hospital duly incorporated under the membership corporations law unquestionably holds itself out as being able to diagnose, treat, operate, and prescribe for human disease, pain, injury, deformity, or physical condition; and such corporations do in fact offer and undertake publicly and frequently through the agency of advertisements to diagnose, treat, operate, and prescribe for such diseases. An institution of this character, possessing legislative authority to practice medicine by means of its staff of registered physicians and surgeons, comes under the direct sanction of the law in so doing, and by the plainest implication, under well-settled rules of statutory construction relating to enactments dealing with the same general subject-matter, are excepted from the operation of the act of 1907 under which the defendant was convicted."

People v. Woodbury Dermatological Institute, 192 N.Y. 454, 85 N.E. 697.

See also *Los Angeles County v. Ford*, 121 Cal. App. 2d, 407, 263 Pac. 2d, 638; and

Johnson v. Stumbo, 277 Ky. 301, 126 S.W. 2d, 165.

Our position is strengthened by the provision in the Dental Practice Act, Sec. 4444, to the effect that no corporation shall own or operate a dental office, but that "the provisions of this section shall not apply to hospitals." It would be anomalous to say

that the legislature intended to exempt hospitals from the prohibition of corporate practice of dentistry and not of medicine. Furthermore, the legislature has recently allowed the formation of corporations to conduct medical clinics under certain safeguards (Sec. 1946c-1948c).

We are aware of the fact that there are Attorney General rulings in other States which hold contrary views than above expressed. A study of these opinions leads us to the conclusion that they are either based on different statutes than exist in this State or on a different factual situation. In any event, we are not bound by rulings affecting other States.

It is therefore our opinion that nonprofit, charitable hospitals are not violating the provisions of the statutes concerning the illegal practice of medicine or surgery when they employ full-time paid specialists, who are licensed physicians, to conduct necessary tests and perform services in the treatment of patients at the hospital.

William L. Beers,

Attorney General

By Louis Weinstein,

Assistant Attorney General

New Secretary to Council on National Defense

Frank W. Barton, a Washington attorney, has taken over the job as secretary to the AMA Council on National Defense. The work which this position entails was formerly carried out by C. Joseph Stetler, who recently became director of the AMA Law Department.

Mr. Barton, who was director of the Claims Division of the War Claims Commission and consultant to the Foreign Settlement Claims Commission in Washington, notified the AMA that he would accept the position on the same day, ironically, that the chairman of the Council, Dr. James C. Sargent, died suddenly in Detroit.

The Council, which was established by the House of Delegates in 1945, assists the armed forces, as well as State and federal civil defense authorities, with medical and health problems and acts as a liaison with allied health agencies regarding personnel facilities and material needed in time of national emergency.

SUNSHINE IN MIAMI

AMA — CLINICAL SESSION — NOVEMBER 29 - DECEMBER 2, 1954

ATTENDING FROM CONNECTICUT

Thomas P. Murdock, Meriden—Member, Board of Trustees
 Norman H. Gardner, East Hampton—Member, Council on Rural Health
 Creighton Barker, New Haven—Member, House of Delegates
 Thomas P. Danaher, Torrington—Member, House of Delegates
 Stanley B. Weld, Hartford—Member, House of Delegates and Reference Committee on Reports of Officers
 C. Lee Buxton, New Haven—Scientific Program Lecturer
 Robert E. Cooke, New Haven—Scientific Program Motion Picture

Dana L. Blanchard, Branford
 S. H. Cohn, Hartford
 Francis J. Cornelio, Winsted
 Edwin R. Connors, Bridgeport
 S. L. Cramer, Hartford
 Joyce V. Deutsch, Southbury
 Thomas M. Feeney, Hartford
 F. C. Fitts, Mystic
 Morris Freedman, New Haven
 Richard F. Grant, Cromwell

Bernard L. Kartin, New Haven
 Henry J. Messinger, Fairfield
 John S. Papa, Bristol
 A. D. Pietra, Middlebury
 Louis Rogol, Danbury
 D. J. Sabia, Stamford
 Benjamin Sachs, Hartford
 A. H. Thomas, Manchester
 Frank S. Vogel, Bristol
 Richard C. Whiting, Hartford
 Poe-Eng Yu, Middletown

House of Delegates

The Miami session brought forth very little of a controversial nature resulting in a minimum of debate. Many problems remain unsolved, are still in process of being studied, and will be reported on at the next session of the House in Atlantic City in June 1955.

PHYSICIANS' LIABILITY INSURANCE

Among these is the matter of malpractice or physicians' liability insurance pertaining to which two resolutions were introduced and referred to the Board of Trustees with a request for a report as soon as possible because of the urgency of the problem.

PREPAID MEDICAL CARE PLANS

The Board of Trustees was asked to give further consideration to the problem resulting from component societies entering into separate agreements with insurance organizations whereby preferential consideration would be given only a part of the insured group.

LAY-SPONSORED HEALTH AND WELFARE PLANS

Difficulties have arisen within certain county societies in Pennsylvania as a result of the establish-

ment within the county of medical facilities by lay-sponsored health and welfare groups. As a result of this the AMA Board of Trustees was requested to study this problem and suggest a proper procedure.

MISCELLANEOUS PROBLEMS REQUIRING FURTHER STUDY

Methods of establishing a better liaison between the medical profession and health and accident insurance carriers will be studied further by the Board of Trustees. The Board of Trustees was further requested by the House to furnish appropriate funds to assist the Council on Medical Education and Hospitals in making an exhaustive study of the problems of the general practice of medicine, including all its phases such as definition of scope and limitations, adequacy of training, limitation of hospital privileges, etc.

The problem of the full time professor in a medical school engaging in private practice in competition with the private practitioner was referred to the Council on Medical Service which is in the process of studying the problem. The osteopathic problem still hangs fire but to date five of the six osteopathic schools have agreed to an "on campus" survey (called observation, not inspection).

The operation of the grievance committee in some State associations has run into difficulties. The Board of Trustees has been requested by the House to appoint a nationally representative committee to study the operation of these committees and make recommendations.

A definition of dental-oral surgery is as yet unsettled and will require further study. Standards of nursing education are being altered, resulting in closure of some schools. The Board of Trustees through its special Subcommittee on Nursing was requested to investigate this situation.

PRESIDENT MARTIN OUTLINES PROBLEMS

In his midyear report to the House of Delegates Dr. Walter B. Martin, AMA president, said: "We have not met our obligation unless we look beyond ourselves to the need of our immediate area, our state and our country." He then pointed out that of first importance is the continued effort to meet the medical needs of the low-income and other noninsurable groups. "It is part of our responsibility," Dr. Martin went on to say, "to see not only that the desire of the American people for protection against the hazards of illness is fulfilled, but that the quality is satisfactory and its usage is not abused."

Referring to the misunderstandings often arising between hospital administrators and professional staffs, President Martin reminded the House that "the practice of medicine is a profession and not a corporate prerogative." In closing: "The medical welfare of our people can best be served by strong local societies, laboring diligently for the total good of their own people. These societies, firmly bound to their state societies and to their national association, can become a strong and moving force for the healing of the nation."

MRS. HOBBY ADVOCATES REINSURANCE

Making a flying visit from Texas to Miami, Mrs. Oveta Culp Hobby, Secretary of Health, Education and Welfare, appeared before the House of Delegates to explain why the Eisenhower Administration strongly supports the reinsurance proposal. She informed the delegates that the Administration is pledged to provide better health facilities for the American people and that the Federal Reinsurance Fund through which the government would share risks of voluntary health insurance would help most Americans pay their medical care. It would not, however, take care of the 30 million indigent and chronically ill who are not insurable and who must

be served by local and state funds. Mrs. Hobby pointed out the fact that the overall cost of medical care is rising and that, in spite of the rapid growth of voluntary health insurance, private medical bills during the past five years have increased by 1.4 billion dollars. The program of reinsurance, according to Mrs. Hobby, is not a federal subsidy but it offers an opportunity for self help by providing funds available to insurance companies who may assume risks greater than standard. "It is not a cure-all," Mrs. Hobby said. "There is no magic in reinsurance. It will not be effective among all groups in the population who need the protection voluntary insurance offers but it does offer this opportunity to the 30 million people not now covered but who can afford to purchase voluntary health insurance. And it offers the opportunity for improved coverage for a sizeable segment of the 99 million who now have some health insurance."

INSURANCE EXECUTIVE CHALLENGES FEDERAL PLAN

Mr. Edwin J. Faulkner, president of Woodmen Accident and Life Company of Lincoln, Nebraska, followed Mrs. Hobby and told the House of Delegates that a Federal Health Reinsurance plan would raise false hopes for a more rapid expansion of health insurance while contributing nothing to the realization of that hope. "Private insurance companies can, without government aid, broaden coverage and work out special policies to meet difficult situations," he said. He further said that government can do much to encourage the purchase of voluntary insurance by tax incentives, and, what was the most important point, that the increase in voluntary health insurance coverage is a selling proposition for the various insurance companies.

GENERAL PRACTITIONER OF THE YEAR

Dr. Karl B. Pace of Greenville, North Carolina was named the 1954 General Practitioner of the Year. Commander of a hospital train in World War I, Dr. Pace, now 66 years of age, has been in active practice in his home town for 40 years. He has worked in so many ways on behalf of his fellow citizens that one of them remarked, "he has been one of the most golden assets of his community." Among other accomplishments he was instrumental in building the first hospital in Greenville.

AMERICAN LEGION OFFERS OLIVE BRANCH

Commander Seaborn P. Collins of the American Legion in a very friendly address to the House of Delegates suggested a joint committee to study the

entire field of veterans' hospitalization aimed at removing that issue "from the area of name calling and propaganda." Asserting that the nation's responsibility and the wishes of the people are "fairly expressed" in the laws governing the veterans' hospital program, Commander Collins said: "The American Legion neither expects nor wants the Government to give carte blanche entitlement to medical care to all veterans. We have not asked for it. The VA's goal is 128,000 beds—for more than 20 million veterans. We are not seeking any major increases in this goal."

Following the suggestion of Commander Collins, the Board of Trustees selected President-Elect Elmer Hess, Dr. David Allman, a member of the Board, and Dr. Louis Orr, chairman of the AMA Committee on Federal Medical Services and member of the AMA Council on Medical Service, to participate in a joint AMA-Legion study on veterans' hospitalization.

UNETHICAL FOR OPHTHALMOLOGISTS TO PROFIT FROM SALE OF GLASSES

The House accepted a report from the Judicial Council which included a joint statement from the three organizations of ophthalmologists in which it was declared unethical for ophthalmologists to profit from the sale of glasses, to accept rebates from optical houses, to profit from the services of an optician, or to engage in any form of fee splitting. The only exception to the last practice is when an insurance company pays a lump sum for a service and there are two or more physicians sharing in the service rendered. In this instance the payments to the physicians should be prorated, providing it is clearly stated to the company and to the patient.

CERTAIN PATENTS ARE ETHICAL

A change in the Principles of Medical Ethics was passed by the House whereby a physician may now patent surgical instruments, appliances and medicines or copyright publications, methods and procedures, but the use of such patents or copyrights or the receipt of remuneration from them is considered unethical if it retards or inhibits research or restricts the benefits derivable therefrom.

GAMMA GLOBULIN

The House of Delegates approved the recommendation from the Committee on Blood that the use of gamma globulin for the prophylaxis of measles

and infectious hepatitis be given priority by physicians because of the fact that the commercial supply this year will be small as compared to the national pool.

The formation of county committees on blood was urged by the Committee on Blood and approved by the House and special attention was called to the problems of small rural hospitals and the need for integrating them into a State blood program.

CONTACT WITH GRASS ROOTS

Out of the Board of Trustees' report on the Washington Office the House urged the Board through its Washington Office to try and discover some mechanism whereby the opinion of each state society on federal legislation could be determined. On the other hand the House approved a resolution calling upon the Board of Trustees to find some method of keeping our entire membership better informed on current medical problems.

GERIATRICS ORGANIZATION APPROVED

The creation of an organization on geriatrics within the present structure of the AMA was approved, this organization to further similar committees in the state and county societies and aid in the dissemination of information in this field to the profession and to the public.

NARCOTIC TAX TO BE ABOLISHED

The Board of Trustees reported that in the future it would no longer be necessary for physicians to send a certified check for \$1 when registering under the Harrison Narcotics Act to obtain the privilege of prescribing or dispensing narcotics. A section contained in HR8300 and approved by the President provides, in effect, that under appropriate regulations uncertified checks may be accepted in payment of taxes imposed by the federal narcotic act. The new law was signed by the President on August 16, 1954, as Public Law No. 591.

AMERICAN MEDICAL EDUCATION FOUNDATION

The Board of Trustees announced that the AMA will no longer be able to provide an annual contribution of \$500,000 to the American Medical Education because of other commitments in its budget. This year the donation will be only \$100,000. The loss to AMEF should be made up by State societies and by individual physicians. Already several State medical associations have included a certain allotment for AMEF in their annual dues.

NATIONAL DEFENSE

Several resolutions relating to national defense were introduced. These and other resolutions submitted at the session in June 1954 are awaiting the result of an exhaustive study being made by the Council on National Defense. This study is being made in an endeavor to determine the possibilities of increasing the attractiveness of the military reserves and the National Guard for physicians.

A resolution from Mississippi was approved whereby the AMA is directed to support the enactment of legislation to provide for voluntary recruitment of medical personnel through federal medical scholarships and suitable career compensations.

The House of Delegates voiced approval of the stand taken by the Board of Trustees to the effect that extension of the "Doctor Draft Law" is not necessary. It is slated to expire June 30, 1955.

VOLUNTARY HEALTH INSURANCE

The Council on Medical Service submitted a detailed report which was accepted, and in addition a supplementary report dealing in particular with simplified insurance claim forms and with the problem of catastrophic illness insurance and insurance for the retired individual. These two latter forms of insurance are being studied and will continue to be studied by the Council.

The Board of Trustees appointed a special commission to study medical- and lay-sponsored health plans now operating in the U. S. Leonard W. Larson, a trustee, of Bismarck, North Dakota is chairman of the commission and other physician members are David B. Allman, Homer L. Pearson, Jr., Joseph D. McCarthy, Percy Hopkins, H. Russell Brown, James R. Reuling, H. Gordon McLean, John Conway, Frank J. Elias and William P. Sheppard. Also Leo Price, director of Union Health Center in New York and Jay Ketchum, executive vice-president of Michigan Medical Service.

GENERAL PRACTICE PRIOR TO SPECIALIZATION

Following a sampling questionnaire sent to four cities, one of which was Hartford, Connecticut, and also to a 25 per cent sampling of American Board diplomates, the interesting fact was revealed that about 90 per cent of those who had done some general practice expressed the belief that it was valuable to them in the practice of their specialty. Also about 40 per cent of those who had not had general practice stated they believed it would have been valuable and advised it for future specialists.

INTERNSHIP PROBLEM

The Ad Hoc Committee on Internships made an outstanding report to the House of Delegates covering many facets of the problem. Internship training programs in all types of federal hospitals were found to compare favorably with other approved programs. Graduates from foreign medical schools should be considered for intern appointment in approved hospitals only under certain conditions which refer to language ability, educational standards, and approval by state licensing boards. Many medical staffs and interns alike do not seem to understand fully the traditional ideals of the medical profession of which service to the sick comes first.

The Committee made several recommendations, all of which were approved. One of these calls for a properly organized rotating internship for all medical school graduates. The Committee expressed its belief that present standards of accreditation are too broad and unrealistic. The ten new medical colleges are either under construction or past the planning stage, but in spite of this potential in an increased number of graduates, increased use of hospital facilities will probably maintain about the same number of internships available over and above the number of interns to fill them, viz., 3,000. And finally, the Committee called upon all hospital staffs now conducting approved programs "to institute a searching reappraisal of the general attitude of the medical staff."

Scientific Lectures, Demonstrations, etc.

The various scientific lectures and demonstrations arranged with a view to being of particular benefit to the general practitioner were held in Dinner Key Exposition Hall. This was formerly the hangar for Pan American's flying boats which used to arrive and depart from the water at this point. Here too were housed the scientific and technical exhibits. Perhaps if one were to select any particular exhibits for their completeness it might be those dealing with the medical and surgical problems of cardiovascular diseases.

Then there were motion pictures shown each day, likewise color television daily. A citation for pioneering in helping to bring educational television to the American public was presented to the AMA by the chairman of the Miami Citizens Committee for Educational Television.

Philadelphia Selected

Philadelphia was selected for the 1957 Clinical Session. Other places scheduled are as follows:

1955—Annual Session—Atlantic City. Clinical Session—Boston.

1956—Annual Session—Chicago. Clinical Session—Seattle.

1957—Annual Session—New York City. Clinical Session—Philadelphia.

Every day the sun put on its best for the visiting doctors from colder climates and every day the physicians of Florida and their wives proved themselves outstanding hosts. It was hard to return to cold and snow.

Dr. Judd to Speak at Rural Health Conference

A physician statesman will be the headline speaker at the AMA's 10th National Rural Health Conference February 24-26 at the Schroeder Hotel, Milwaukee, Wisconsin. The Honorable Walter H. Judd, M.D., congressional representative from Minnesota, will speak on "Rural Health and World Peace" at the Friday evening banquet. Also featured on the banquet program will be the Medichoir—composed of 45 medical students from the University of Wisconsin.

Other highlights of the Conference sponsored by AMA's Council on Rural Health include: Panel discussions on farm and home safety; family responsibility for health; using our present health and medical care resources. Also, a resume of success stories including presentations on a joint medical society-industry-farm group medical clinic project in Marinette, Wisconsin; a seven-northwestern-state survey of rural health facilities; a weight control, nutrition and health project in Rockford, Illinois, emphasizing physician-public health-extension service cooperation, and securing a doctor in a joint community venture in Tennessee. J. P. Schmidt, professor of rural sociology at the University of Ohio, will be the general discussion leader.

At the final luncheon, Leonard W. Larson, M.D., AMA trustee and one of the original Council members, will trace the Council's development and activities during its first 10 years. Dr. F. S. Crockett, Council chairman, and Mrs. Charles W. Sewell, Council member-at-large, will open and close the Conference with brief inspirational messages.

Co-op Dissolves

The Executive Committee of the Group Health Council, Inc., has voted to dissolve the corporation and terminate its existence. The Group Health Council, Inc., whose headquarters was in New Haven, was organized a few years ago with its purpose stated as "an association to promote the formation of a voluntary program for comprehensive medical care." Its objective was to organize a cooperative medical service plan patterned closely after the Health Insurance Plan of New York (HIP) and provide all medical services for its subscribers by groups of physicians paid on a capitation basis. The Council published a prospectus of its plans stating what the contract would provide and the premiums that would be charged but there was no evidence that its proposals had the approval of the Insurance Department of the State of Connecticut. From time to time, enthusiastic representatives of HIP conferred with the Council and made speeches in promotion of the HIP idea. Members of the State Medical Society were invited to confer with the Council and did so, participating in frank discussion of the purposes of the Council and the problems presented. The reason for the dissolution of the corporation is stated to be the discouraging experience in lack of interest on the part of the people in the objectives of Group Health Council, Inc., and lack of support. Funds remaining after existing obligations are paid, will be given to the State Industrial Union Council, C.I.O., and the Connecticut Federation of Labor, A.F.L.

The Mentally Ill

Science (Nov. 19, 1954) reports that the National Association for Mental Health has released some striking figures about the extent of mental illness and the lack of facilities and trained personnel for the care and treatment of the mentally ill.

1. This year about 250,000 persons will be admitted to mental hospitals for the first time.
2. At the present rate, one of every 12 children born each year will need to go to a mental hospital some time in his life.
3. More than one-half of all of our hospital beds are occupied by mental patients.
4. Mental illness costs us over \$1 billion a year in tax funds.

THE WORLD MEDICAL ASSOCIATION

The eighth annual general assembly of the World Medical Association was held in Rome, Italy, during the latter part of September and the first of October of 1954. Those who attended will remember forever the beautiful buildings in which the Association's officers, delegates and visitors met and were entertained. Italy long has been known for the warmth and friendliness of its people but only those who experienced this can fully appreciate the courtesy and kind attention shown at this meeting.

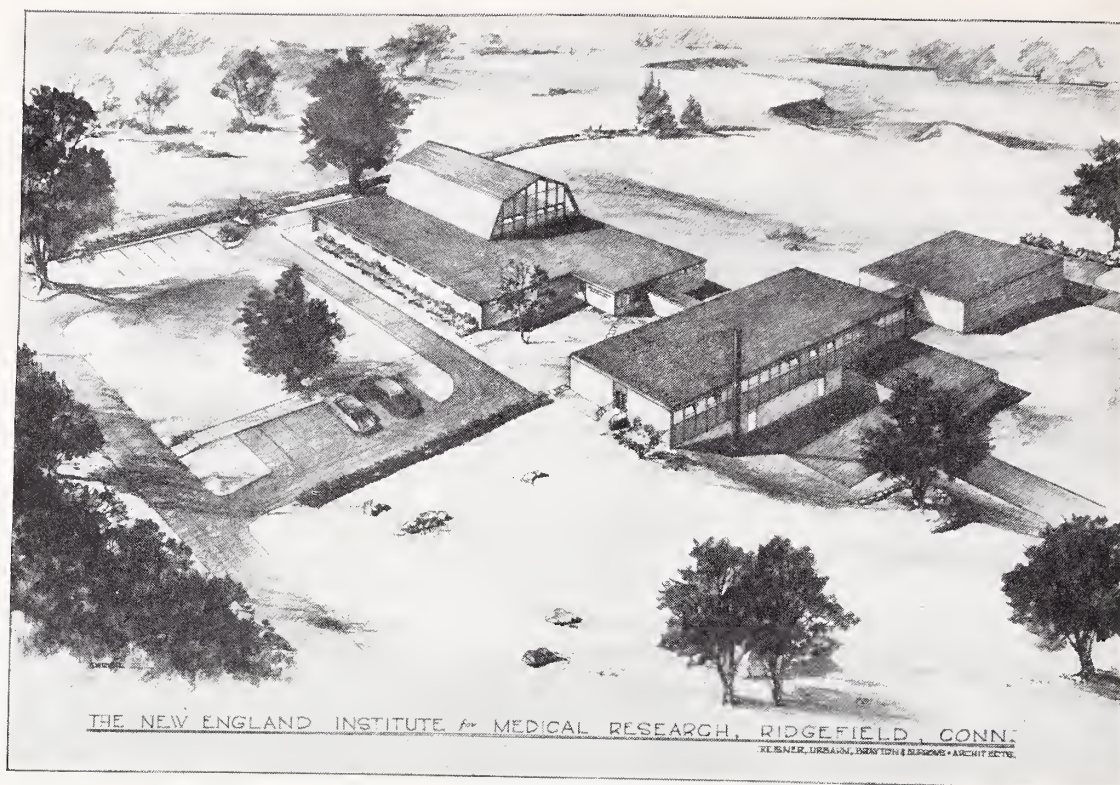
Among the topics discussed were cost of medical care, human experimentation, supply of doctors, use of drugs, medical ethics, medical education and occupational health. Considerable discussion was devoted to the first World Conference on Medical Education which was held in London, 1953, under the auspices of the World Medical Association. Plans also were revealed for a second such conference, this one to be held in North America in 1959. The proceedings of the 1953 conference are now available in book form from the Oxford Press. Also discussed with much interest were the plans for a World Conference on Occupational Health under the auspices of the W.M.A. This will be held within the next few years. Details of this and other W.M.A. activities will appear in the *World Medical Journal*.

The World Medical Association is a young organization, it being only eight years old but it already has exerted influence on world affairs of a medical nature. Whether the subject is scientific, economic or political, if it involves medicine, the W.M.A. is actively interested. This is possible because of the support given to it by national medical associations and because it is free of government control. Unfortunately, the W.M.A. is still confused by some people with the World Health Organization. This is unfortunate because the former consists of national medical associations and their members and the latter is made up of representatives of government. This difference is of fundamental importance to the doctors of the world and to their patients. Doctors in North America enjoy a type of freedom not always found in other countries. And yet doctors throughout at least the free part of the world are united in their desire to give the best possible medical care without being hampered by bureaucratic control as they discharge their duties.

The financial affairs of the World Medical Association has always been a matter of concern because the growth of the Association threatens to outrun the financial sources. The doctors of America, members of the drug industry and some other well wishing supporters have provided much help over the past eight years. This has been necessary for several reasons, one important reason being the difficulty of transferring funds from some countries. The American supporters have been banded together in what is known as the United States Supporting Committee. This program which has been helpful here is now being developed in other countries, for example, Canada, Great Britain, Switzerland, Sweden and the Philippines. Other countries have organized or are about to organize similar committees. Their full effectiveness will not be felt, however, for several years and it therefore remains urgent for many more doctors in the United States to join the U. S. supporting committee. Dues are only ten dollars for which the member receives the *World Medical Journal* and considerable other material. Dues can be paid to the office in New York City (345 East 46th Street) and are a sound investment in the preservation of freedom of medical practice. If one doubts this he has only to inform himself of some of the socialistic proposals offered by the International Labour Office and the International Social Security Association and to look at the record of the World Medical Association in standing up to such proposals. The World Medical Association has an enviable record behind it. Its future depends to a large extent on the support given to it by doctors such as those in the House of Delegates.

At the eighth Assembly, Dr. Edwin S. Hamilton was elected to succeed Dr. Austin Smith as a member of the Council of the World Medical Association. Dr. Smith's term of office had expired. He continues to serve the W.M.A. as its executive editor. The other member of the Council from the United States is Dr. Gunnar Gunderson, also of the Board of Trustees.

The Ninth General Assembly will be held in Vienna, Austria, in 1955. It is not too early for those who wish to attend to begin making their plans now.



The New England Institute for Medical Research

A nonprofit, privately supported organization devoted to fundamental medical research and known as the New England Institute for Medical Research is to be formed in Ridgefield, Connecticut. The Institute is designed to enable physical scientists to participate more fully in medical investigation. With the growing development of complex electronic, radioactive, and other physical theories and devices, a distinct need has been created for an institution where physical scientists and medical men may work side by side without financial limitations imposed by the annual grant type of research financing which most medical schools are compelled to rely upon. Today almost all semiprivate educational research institutions are in financial trouble. They are able to give no more than token support, i.e., the salary of the professor, to the research.

The plans for the building include a square footage of the order of 25,000. There will be a small clinical wing, which will have examining and treatment rooms, and which will have two beds for any acute experimentation which requires such facilities.

Specifically, there are relatively scanty radioisotope facilities in this part of the State, so that if an ophthalmologist desires to use a beta applicator,

or a surgeon wishes to give radio-gold, etc., he may use the facilities of the Institute.

The Atomic Energy Commission does not permit the use of isotopes by personnel who have not had an adequate amount of experience with isotopes. Consequently, the Institute plans to make available trained personnel to help physicians who wish to use isotopes. They may also use this facility to acquire the necessary training, so that they may become authorized to use isotopes.

The personnel will be comprised of M.D.'s and PH.D.'s. It will represent, in addition to several medical specialties, physical chemistry, biochemistry, radiation physics, physiology, pharmacology, virology, and immunobacteriology.

The personnel of the Institute will be available at all times to the doctors of the area, but no patients will ever be seen directly—only by referral, and then preferably with the local physician.

The Institute is working in conjunction with individuals and departments at Yale, Cornell, Brookhaven, the University of Utah, Harvard, etc. There will be laboratories for physical chemistry, biochemistry, surgery, physiology, pharmacology, radio-chemistry, histology, etc., as well as a linear electron accelerator which will develop electrons of several million volts.

A library of the order of 10,000 books will be available. This library, and of course the librarian, will be available to all the physicians of the area. There will also be a seminar room for meetings, as well as a lounge for informal groups.

The personnel will be appointed by the Scientific Board of the Institute, and several Fellowships will be available. Certain Scholarships, Fellowships, and Investigatorships will also be made available to selected individuals in various universities.

The first Investigatorship has been given to the Department of Physiology at Yale University to Dr. Elmer R. Gabrieli.

The funds for the New England Institute for Medical Research come from individuals and foundations, and some from industry (e.g. Becton-Dickinson). Several of the donors prefer to remain anonymous. All funds, from whatever source, are given free and clear of any obligation, actual or implied.

Dr. Fulton Receives Honorary Degree

At the medical centennial celebration of Emory University, Georgia held in October, 1954 Dr. John F. Fulton of Yale University School of Medicine received the honorary degree of doctor of science. On the same occasion the honorary degree of doctor of science was conferred upon Dr. Stanhope Bayne-Jones, director of U. S. Army medical research and formerly a member of the Connecticut State Medical Society.

REPORT OF THE COMMITTEE ON SCHOLARSHIP AWARDS—HOUSE OF DELEGATES, DECEMBER 9, 1954

In 1953 this House of Delegates authorized the allotment of \$2,000 from surplus funds of the Society to provide three medical school scholarships in the amount of \$500 each and \$500 to be divided appropriately for scholarships in schools of nursing. The three medical school scholarships were awarded, as were three nursing school scholarships totalling \$500.

Acting on the same subject for 1954, the House voted an appropriation of \$2,500 to provide five medical school scholarships of \$500 each. The nursing school scholarships were discontinued because of the large sum of money appropriated by the State of Connecticut to provide such scholarships.

Rules governing the award of the scholarships are simple. The applicant must have his home residence in the State of Connecticut and be in his fourth or final year in an approved medical school in the United States or Canada.

Selection of recipients is made by a Scholarship Award Committee appointed by the President of the Society each year. The membership of this committee is known only to the president and the executive secretary of the Society who serves as recorder for the committee. In making the awards, the committee gives consideration to three factors: (1) economic need; (2) scholastic achievement; (3) potentials as a citizen and physician.

It is now my pleasure to announce the awards for 1954 as selected by the committee. There were forty applicants.

EDWARD D. COPPOLA, Waterford, Connecticut—age 24, son of Edward A. Coppola, M.D., a member of this Society, retired from practice because of illness. Mr. Coppola received his Bachelor of Arts, Magna cum Laude from Amherst College in 1951, was also a member of Phi Beta Kappa. He is a senior student in the Yale University School of Medicine.

ROBERT A. GOYER, Collinsville, Connecticut—age 27, son of Andrew Goyer, retired due to physical disability. Mr. Goyer received his Bachelor of Science Degree from Holy Cross College in 1950. He ranks in the middle third of the fourth year class of St. Louis University School of Medicine.

DANIEL J. LION, New Haven, Connecticut—age 29, son of Peter Lion, a laundry employee. Mr. Lion received his Bachelor of Science from Fordham University in 1950, where he was on the Dean's List for four years. He was a Private in the Glider Infantry in the European Theater during World War II, where he participated in three campaigns and was awarded the Purple Heart. He is a member of the fourth year class of the State University of New York College of Medicine at New York City.

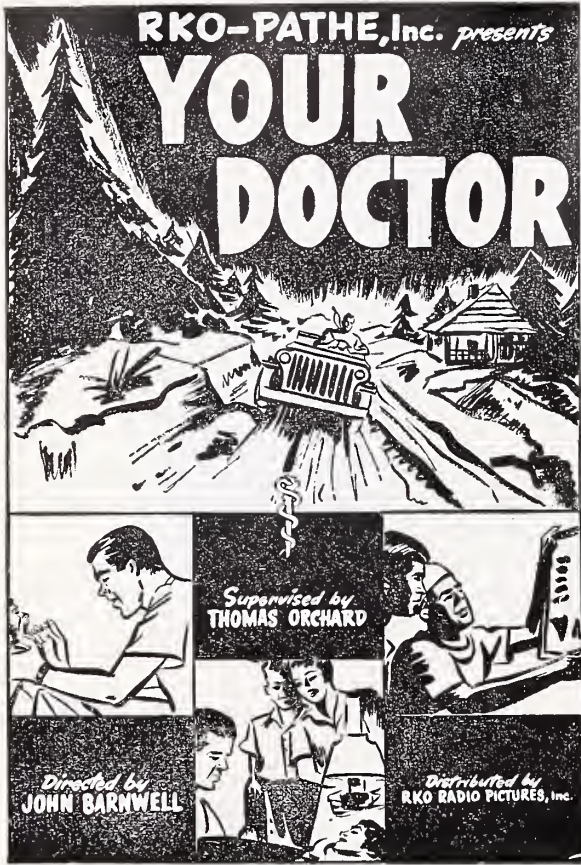
ARTHUR J. MCPADDEN, JR., Bridgeport, Connecticut—age 27, son of Arthur J. McPadden, factory paymaster. Mr. McPadden attended the University of Connecticut and received his Bachelor of Arts Degree from Lafayette College in 1951, where he was a member of Phi Beta Kappa. He is a fourth year student at the University of Vermont College of Medicine.

WILLIAM VOUNATSO, Hartford, Connecticut—age 25, son of Stratis Vounatso, deceased. Mr. Vounatso received his Bachelor of Science Degree from Trinity College in 1951 where he was a member of Phi Beta Kappa, and a William Topham Scholar for three years. He ranked fifth in the entire college at the time of his graduation. He ranks in the upper fourth of the senior class in the University of Pennsylvania School of Medicine.

The Society's checks in the amount of \$500 each will be sent to these young men at Christmas time.

I wish to suggest that appropriate measures be taken by the Council and House of Delegates at its Annual Meeting in April to continue this scholarship program in 1955.

H. M. Marvin, President



Produced by RKO-Radio Pictures in cooperation with the American Medical Association, the documentary film, "Your Doctor," is available in a 16 millimeter edition for schools, churches, clubs and civic organizations.

This fifteen-minute sound film tells the story of Dr. George Bond's North Carolina mountain clinic, of how medical students are trained and of the relationships between physicians and their medical societies.

A copy of the film may be borrowed by any community organization without charge except for postage and insurance.

Physicians can help advance this educational program by calling the film to the attention of organization leaders. The booking coupon on this page may be used to reserve the film.

Connecticut State Medical Society
160 St. Ronan Street
New Haven 11, Connecticut

Please reserve a 16 mm. print of YOUR DOCTOR for our group.

Name of Organization or School

☐ If film is not available as requested please schedule for first open date.

Date to be Shown Alternate Date

ADDRESS TO WHICH FILM IS TO BE SENT

Name (Please Print)

Street

City Zone State

Signature Title

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington

Chairman

Harold A. Bergendahl, Norwich

Burdette J. Buck, Hartford

James C. Canniff, Torrington

Morris A. Hankin, New Haven

Harry C. Knight, Middletown

James H. Root, Jr., Waterbury

Alfred J. Sette, Stamford

More Than 100,000 Fairgoers View Health Exhibits

More than 100,000 persons attended 11 of the 15 county fairs at which health exhibits were sponsored by the Society's Committee on Rural Health and Connecticut Medical Service, in cooperation with the Woman's Auxiliary to the Society.

It is anticipated that the total combined attendance may pass 150,000 when reports are received from the four other fairs. The attendance at each of the fairs has been reported as follows: Woodstock Fair, 20,000; Fairfield County 4-H Fair, 2,000; Middlesex County 4-H Fair, 5,000; Union Agricultural Society Fair, 20,000; Goshen Fair, 15,800; Chester Fair, 8,000; Riverton Fair, 9,000; Hamburg Fair, 3,000; Wethersfield Grange Fair, 400; Bethlehem Fair, 9,000; Hartford County 4-H Fair, 6,500.

Capacity Audience Attracted to First Health Forum in New York City

The question whether public health forums sponsored by medical associations can be successful in large cities appears to have been answered in a clear affirmative by the recent forum held in New York City under auspices of the Medical Society of New York and the *New York Daily Mirror*.

The forum was attended by an audience of more than 2,200 persons and its success has encouraged the planning of a series of six additional programs.

Commenting on the New York project, Dr. Peter M. Murray, president of the Society, said that "physicians are not, or need not be, men in white coats in the 'ivory towers' of research as they are often dramatized and they can talk in the language of the man on the street so that truth and knowledge about medical and health information can replace the fear and ignorance which is too often in the layman's mind because of superstition or misinformation."

Eighteen Articles on Health and Medical Care Published in December Magazines

Eighteen articles on subjects ranging from new drugs to rural health and budgeting the costs of medical care were published in national leading magazines during the month of December.

None of the articles contained criticism of the medical profession and all were strongly positive in the advancement of health education.

Advance information concerning January publications indicates that Dr. Walter B. Martin, AMA president, will be one of several national figures to be quoted in *Look's* January 11 issue on predictions for the coming year. The January issue of *Science Digest* will reprint an article titled "How To Pick a Doctor" published in the November issue of the *American Legion Magazine*.

December magazines published the following articles: *McCall's*—"This P.T.A. Built a \$700,000 Clinic," by Arthur Gordon; *Redbook*—"Better Hospital Care For You Now," by John Kord Lagemann; *Changing Times*—"Better Health For Less Money," by Lois Felder; *Life* (Nov. 29 issue)—"A New Doctor Moves In"—a picture story; *Family Weekly Magazine* (Dec. 26 issue)—"Community War-Cry: Beat Mental Illness," by W. D. Severin; *Saturday Evening Post* (Dec. 4 issue)—"Cold Can Save Your Life," by Ben and Marie Pearse; *Coronet*—"What Is Hypnotism?," by Norman Carlisle; *Coronet*—"New Hope For the Deaf," by Morton Hunt; *Look* (Dec. 14 issue)—"Exercise Can Help Your Heart," by Roland H. Berg; *Collier's* (Dec. 10 issue)—"Are You Bitter-Sweet or Bitter-Bitter?," by J. D. Ratcliff; *Collier's* (Dec. 10 issue)—"Schizophrenia," by Toni Taylor; *Woman's Home Companion*—"Do You Know What's Good For You?," by Amelia Lobsenz; *Reader's Digest*—"The New TB Drugs—A Progress Report," by Lois Mattox Miller; *Family Weekly Magazine* (Dec. 26 issue)—"How To Sleep Soundly," by Jerry Klein; *Life* (Dec. 6 issue) "Horizons

of Hope,"—a film; *Pageant*—"Pills That Chase Away the Blues," by Donald G. Cooley; *Redbook*—"Paul Orva's Private Miracle," by Richard Carter; *Cosmopolitan*—"What's New in Medicine"—a column; *McCall's*—"News in Child Health"—a column by Marguerite Clark.

More Than 300 Attend Miami PR Conference

More than 300 chairmen of medical public relations committees and medical association executives attended the seventh medical public relations conference held in Miami, November 28, during the clinical session of the American Medical Association. The conference opened with an address by Dr. George F. Lull, AMA secretary and general manager, who stressed the importance of continuous internal information programs in strengthening medical association relationships.

Quoting from a letter written in 1897, commenting upon several of today's medical problems which also existed at that time, Dr. Elmer Hess, president-elect of the AMA, emphasized that while some problems may not be new it is often wise to seek new ways to deal with them.

At the afternoon session of the conference one of the principal speakers, Daniel Mich, editorial director of *Look Magazine*, spoke on the topic "Why Magazines Write About Medicine." He presented several reasons for the continuing popularity of articles on medical subjects, chief of which are the many opportunities presented for writers to develop reader interest by permitting the reader to identify himself with the story being told.

Several panel discussions featured the conference and by special arrangement previews of two national television productions were presented.

Reaction of Public to Science News Subject of New Survey

The National Association of Science Writers has announced that it will soon conduct a national survey to learn the public's reaction to medical articles and other science news.

The study will be financed by a \$10,000 grant from the Rockefeller Foundation and is designed to help make science news as meaningful as possible to readers.

The writers' organization plans to engage professional opinion researchers to poll the attitudes of a large cross-section of the public toward science reporting by newspapers, magazines, television, radio, and motion pictures.

Medical Society Scholarships Awarded to Five Senior Medical Students

The recipients of five medical school scholarships granted by the Connecticut State Medical Society were announced at the semi-annual meeting of the Society's House of Delegates December 9, in New Haven.

They are Edward D. Coppola, Waterford; Robert A. Goyer, Collinsville; Daniel J. Lion, New Haven; William Vounatso, Hartford; and Arthur J. McPadden, Jr., Bridgeport.

The youngest of this year's award winners, Edward D. Coppola, is 24 years of age and the son of a physician, Dr. Edward Coppola, of 2 Highland Drive, Waterford. A senior student at the Yale University School of Medicine, he is a 1951 honor graduate of Amherst College, where he won Phi Beta Kappa membership.

Robert Goyer is the son of Andrew Goyer, 172 Thayer Avenue, Collinsville. He is a 27 year old senior student at St. Louis University School of Medicine and received his academic degree at Holy Cross College in 1950.

Daniel Lion, 29, the son of Peter Lion, 152 Columbus Avenue, New Haven, graduated from Fordham University in 1950 and is a member of the fourth year class at the State University of New York College of Medicine, New York City.

William Vounatso, 25, is a senior student at the University of Pennsylvania School of Medicine. He is the son of William Vounatso, deceased, and his family residence is 617 Broad Street, Hartford. He graduated from Trinity College, where he became a member of Phi Beta Kappa and was a William Topham Scholar for three years.

Arthur J. McPadden, Jr., 27, is the son of Arthur J. McPadden, 245 Hawley Avenue, Bridgeport, and a member of the senior class at the University of Vermont College of Medicine. He attended the University of Connecticut and later transferred to Lafayette College where he was a member of Phi Beta Kappa and received his academic degree in 1951.



Dr. Thomas F. Hines Cited For Outstanding Service to the Handicapped

Dr. Thomas F. Hines, right, director of physical medicine and rehabilitation at the Grace-New Haven Community Hospital, and assistant professor of medicine, Yale University School of Medicine, is shown in this picture receiving a citation for outstanding service by the President's Committee for Employment of the Physically Handicapped. Dr. H. M. Marvin, center, president of the State Medical Society, congratulates Dr. Hines in company with Edward P. Chester, left, director of vocational rehabilitation for the Connecticut State Department of Education and a member of the Connecticut Committee for Employment of the Physically Handicapped, who presented the citation.

The citation was presented to Dr. Hines at the semi-annual meeting of the Connecticut State Medi-

cal Society's House of Delegates December 9 in New Haven. During the presentation ceremony Mr. Chester traced Dr. Hines' interest in the problems of handicapped persons and told how it has resulted in major contributions in physical rehabilitation and how it has encouraged employment of those who have been aided through these programs.

Dr. Hines directed the establishment of the present poliomyelitis clinic at the Grace-New Haven Community Hospital in 1952 and last year this was followed by the establishment of a clinic for rehabilitation of the physically handicapped. The rehabilitation clinic now utilizes the services of 14 physical therapists and facilities include a 31 bed ward and equipment necessary for special patient care.

Since the program has been started the hospital has received a grant of \$20,500 for increasing physical therapy services from the National Foundation

for Infantile Paralysis. Another grant by the Foundation has provided the sum of \$150,000 for rehabilitation teaching at the Yale School of Medicine. Dr. Hines is chairman of the medical school's rehabilitation study unit for medical students and postgraduate physician education. Another major step in the rehabilitation program is anticipated when present plans are perfected to establish a clinic for muscular dystrophy in a coordinated program with the hospital's Department of Neurology.

Dr. Hines is acting chief of physical medicine and rehabilitation for the Connecticut Commission for the Chronically Ill, Aged and Infirm and is district medical consultant for the Bureau of Rehabilitation. He is a consultant on physical medicine and rehabilitation for the Waterbury Hospital; the Charlotte Hungerford Hospital, Torrington; Gaylord Farm Sanatorium, Wallingford; and for the Veterans Administration Hospitals in West Haven and Newington.

Medical advisor for the Connecticut Chapter of the American Physical Therapist Association and the Connecticut Occupational Therapy Association, Dr. Hines is a certified member of the American Board of Physical Medicine and Rehabilitation. He has served as chairman of the New Haven County Chapter of the National Foundation for Infantile Paralysis and is a member of the Board of Directors of the New Haven Area Rehabilitation Center and the Goodwill Industries, New Haven.

A member of the New Haven County Medical Association, the Connecticut State Medical Society and the American Medical Association, Dr. Hines received his medical degree at the University of Pittsburgh School of Medicine in 1941. He served with the Army in World War II from July 1943 to March 1946, including 27 months overseas, and received his separation from the service in the rank of major.

From early in 1946 to December, 1947 he served in the Department of Medicine at the Veterans Administration Regional Office in Wilkes-Barre, Pennsylvania, his native state. He was born in Berwick, Pennsylvania, July 27, 1917. Dr. Hines held a fellowship in physical medicine and rehabilitation at the Warm Springs Foundation, Georgia and Emory University Hospital, Atlanta, Georgia from January, 1948 to February, 1951. In March, 1951 he received the present appointments at the Yale University School of Medicine and Grace-New Haven Community Hospital.

Alien Physicians

The number of alien physicians on U. S. hospital staffs has more than doubled in the last three years, according to a report published by the American Medical Association.

During the 1953-54 school year, 5,589 foreign physicians held appointments as interns, residents or fellows on house staffs of the 800 civilian hospitals approved for such training by the Department of State. Three years before the total was 2,072.

These aliens cut the number of vacancies in those hospitals down to 20 per cent for residents and 30 per cent for interns. The report states that without them the percentages would have been "considerably greater, since many young physicians who would normally be taking postgraduate work are on active military duty." Aliens made up 22 per cent of the total house staffs in the approved hospitals.

Largely because of State licensing laws, more than two-thirds of these foreign doctors were located in five States, New York, Ohio, New Jersey, Illinois and Massachusetts. In New Jersey, 65 per cent of the house staff positions were filled by aliens.

The report was prepared by Dr. Harold S. Diehl, Dr. Edwin L. Crosby and Paul K. Kaetzel. Mr. Kaetzel is with the Health Resources Advisory Committee of the Office of Defense Mobilization.

Leads in New Business

Connecticut stands well near the top among the States in the number of new businesses according to U. S. Department of Commerce studies recently published in the Information Letter issued by the Connecticut Development Commission. It is further evidence of the fact that Connecticut's economy often goes contrary to the trend for New England.

The total number of businesses in operation this year in New England, according to the Federal study, declined by approximately 2,000. In Connecticut, however, there was an increase of approximately 900. Rhode Island was the only other State in the region to show a gain.

Connecticut also ranked high in the national picture in the absolute number of businesses gained during the past year, standing 14th among the States in this regard, although the State ranks 28th in population. Even gigantic New York State gained fewer businesses. The U. S. Department of Commerce estimates the total number of businesses operating in Connecticut now at 63,500.

NEWS FROM WASHINGTON

Fellowship Stipends Not Taxable, Court Rules

In a decision affecting 32,000 foundations and many thousands of physicians, scientists, and scholars, the Tax Court of the United States has held that research and study grants from philanthropic organizations are not taxable. The decision, which reverses a 1951 finding of the Commissioner of Internal Revenue, holds that fellowships are gifts, and therefore are not taxable as income. Previously, grants were regarded as income, and taxable as such. The Tax Court ruling came as the result of a test case brought by George Winchester Stone, Jr., a Washington (D. C.) professor, in regard to a Guggenheim Foundation literature grant.

FDA Sets Up Procedure for Removing Rx Legend

Food and Drug Administration has set up a standardized procedure for removing prescription requirements from certain drugs and placing them in the over-the-counter category. Under the Durham-Humphrey law, drugs may not carry the legend ("Caution: Federal law prohibits dispensing without prescription") while at the same time carrying directions for use by the general public. Until now the procedure for effecting the change has not been formalized, although a number of prescription drugs have been made available to the public. Under the new procedure, the change may be initiated by the FDA commissioner on his own decision, or on the filing of a petition by an interested party. Next step is publication in the Federal Register, with a request for comments. The commissioner may call a public hearing before putting the change into effect. FDA emphasized that comments from the medical profession as to the safety of a drug for lay use will be welcomed in every case where the commissioner proposes to replace the legend with directions for use.

Defense Proposes Four-Year Extension of Regular Draft

The administration wants the regular draft which expires next June 30 extended for another four

years. In making this disclosure at a Pentagon press conference, Secretary of Defense Charles Wilson left unanswered for the time being just what are the administration's plans for the doctor draft which also expires in mid-1955, and which is a part of the regular draft law. This issue is scheduled for settlement in the near future. Mr. Wilson said details of the program for long-range, modified reserve training were being worked out, and probably would be included in the President's State of the Union message in January. It is estimated that the regular draft would continue to take about 23,000 young men each month. The reserve program would provide six months training for 50,000 to 100,000 men a year, with an obligation to participate actively in reserve or National Guard units.

The Secretary said Congress likewise would be asked to grant military pay raises averaging from 3 to 5 per cent at an added cost of \$600,000,000 a year. It is proposed to give higher raises to men with certain technical skills and to those who agree to long-term service.

Large Doctor Draft Call Issued

More than twice the number of men taken in the last Doctor Draft call will be tapped for April induction, Defense Department announces. This is presumably the last medical officer call under the present Doctor Draft Act, which is scheduled to expire on June 30. The Defense Department has asked Selective Service for 1,275 physicians—825 for the Army, 200 for the Navy, and 250 for the Air Force—and 459 dentists for the three month period starting next April. The last quarterly Doctor Draft call, issued for December, took 550 physicians and 150 dentists. Priority three men (doctors not educated at government expense who have served no time on active duty) will comprise the majority of those taken in April, Defense Department says.

Army Secretary Outlines 5 Point Program for Career Servicemen

Secretary of Army Robert Stevens, addressing the Retired Officers Association in Washington November 29, spelled out the Defense Department's plan for making a career in the armed services more

attractive. The 5 point legislative program being drawn up for submission to the 84th Congress, he said, includes provision of "more reliable" medical care for dependents of military personnel. While not elaborating on this point, the Secretary made this observation:

"Many of our younger officers are concluding that it just isn't worthwhile to remain in a profession where the responsibilities are so great and the rewards so modest. To insure that the future leaders of this nation's military forces will meet the same high standards we have come to take for granted, it is essential that we restore a full measure of dignity to the honored profession of arms. It is vital to our national security that the career service be attractive to the highest type of young American."

The department's legislative program also includes: (1) substantial pay raise for all military personnel, (2) comprehensive revision of benefits for survivors, (3) special allowances for service families transferred from one permanent station to another, and (4) tax exemptions for retired pay.

1953 Figures Given on U. S. Medical Expenses

A statistical report just completed by Division of Research and Statistics in Social Security Administration presents a comprehensive picture of medical care and hospitalization costs in 1953 and extent to which they were defrayed by insurance coverage. Private expenditures are estimated at \$9,866,000,000. Blue Cross, Blue Shield, commercial insurance (both group and individual), union plans and all other types of coverage provided benefits totaling \$1,919,200,000, according to the report.

Breaking down the figure of \$9,866,000,000, the government summary attributes 29 per cent to physician's services and 28.6 per cent to hospital charges. Remainder is as follows: Medicines and appliances, 22.2; dentists' services, 9.6; other professional services, 5.7; net cost of insurance for hospitalization, 2.9, and net cost of insurance for medical care, 2 per cent.

All insurance plans and carriers combined had aggregate earned income of \$2,404,600,000, with Blue Cross in No. 2 position—\$708,400,000. Commercial insurance was first with \$1,181,400,000, about two-thirds of which was in group coverage.

Other categories: Blue Shield plans, \$280,200,000; community nonprofit plans, \$56,300,000; union health and welfare plans, \$81,700,000; employer-employee plans, \$49,600,000; prepayment group clinics, \$17,800,000; miscellaneous, approximately \$30 million.

Eighty cents of every dollar invested in health insurance of all kinds came back in form of benefits. By categories, this percentage ranged from 50 for holders of commercial insurance written on an individual basis up to 100 in the case of student health services. Blue Cross paid 88 per cent of premium income in benefits, Blue Shield 80 per cent.

Income loss in 1953 due to short-term illness and first six months of extended disability was estimated at \$6.1 billion. Less than 10 per cent was met by insurance.

PHS Expands and Reorganizes Commissioned Reserve

A major reorganization and expansion of the Commissioned Reserve of the Public Health Service is now under way. Plans call for the commissioning of an additional 2,000 reserve officers by next June 30, and another 3,000 during the ensuing fiscal year. Action comes as the result of extensive new defense responsibilities assigned to PHS by the Federal Civil Defense Administration. Also scheduled is an expansion of research in disaster health problems and development of a program to reinforce state and local health departments in time of national crisis.

Officers of the emergency reserve will be called to active duty without their consent only in the case of a national emergency, but may request active duty at any time, and will be considered for available assignments. Initial emphasis will be on the commissioning of physicians, dentists, sanitary engineers and nurses, followed by training of officers in health problems associated with atomic, biological and chemical warfare.

**Your Physicians Annual
State Registration Tax
is due January 31**

Connecticut Committee on Foods, Drugs, Cosmetics and Devices

Meeting of October 7, 1954

The member societies and institutions were represented at this meeting as follows: Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut Pharmaceutical Association, Prof. Nicholas W. Fenney; Connecticut State Dental Association, Dr. William Kirschner; Connecticut Veterinary Medical Association, Dr. Joseph DeVita; University of Connecticut, Dr. Stanley E. Wedberg; University of Connecticut College of Pharmacy, Dean Harold Hewitt; Yale University School of Medicine, Dr. Desmond D. Bonnycastle.

The following were also present: Dr. James C. Hart, representing the State Department of Health; Mr. Heroert Plank, representing the Food and Drug Commission.

INFORMATION SERVICE ON ANTIDOTES FOR

COMMON POISONS

Dr. Bonnycastle reported that New York State had recently passed a law requiring all household products containing poisonous materials to carry the names of the ingredients and the antidotes therefor; Dr. Plessen had received a copy of the regulations under this law but did not have the text of the law itself.

Edward Press, M.D., chairman of the Accident Prevention Committee of the Illinois Chapter of the American Academy of Pediatrics, had prepared a rather elaborate mimeographed handbook on household poisons which he intended eventually to publish in printed form; there was a copy of this handbook in the Yale School of Medicine, and Dr. Bonnycastle had been able to secure another for the Committee's use.

The conference had agreed that the possibility of Connecticut's passing a law similar to that of New York should be explored. It was also agreed that it was worth while to expand and then distribute the present list of Drs. Johnston and Plessen and set up some sort of information service. Estimates as to the number of items the list should eventually encompass ranged from 60,000 to 250,000.

It was the consensus of the members that a list arranged by antidotes would not meet the problem, because in practice what happened was that a child swallowed a commercial product of undeclared composition, and what the doctor needed first and most of all was information on what the ingredients of the product were; once he had this information he could decide himself whether to pump the

stomach out, administer an antidote or let the child alone.

THE SALE OF DENTAL-PLATE RELINERS IN RETAIL PHARMACIES

Dr. Fisher stated that this topic and the following one had been referred to this Committee by the Joint Committee of the State Medical Society and the Pharmaceutical Association on August 10. Prof. Fenney explained that Dr. Gilbert LeVine Mellion, a New Britain dentist who practiced in Wethersfield, had been concerned about plastic reliners offered for sale in this State because he believed they might damage plates and thereby affect the health of the users. Asked about the extent to which these "Briggs Plastic Dental Plate Reliners" were sold in pharmacies, Prof. Fenney said that most pharmacies did not carry them.

Dr. Kirschner remarked that he doubted very much whether these liners would damage plates, but that he did think they might do irreparable damage to the mouth itself by camouflaging a condition needing treatment. The trouble might not lie only in the fit against soft tissues (due to a change in the denture); a change in the jaw might be involved, and when this change went far enough the reliner could no longer make the patient comfortable.

It was agreed that Prof. Fenney would get a sample of the Briggs Reliner and Dr. Kirschner would report on it at the next meeting.

THE SAFETY OF BARLEY SUGAR LOLLIPOPS AS REGARDS DENTAL DECAY

This question had also been referred by the Joint Committee; Prof. Fenney said that it had arisen with Dr. Mellion.

Dr. Wedberg remarked that it was true that maltose was readily hydrolyzed to dextrose. On motion of Dr. Fisher, seconded by Dr. Wedberg, it was voted to refer the topic to Dr. Kirschner for a report at the next meeting.

CIG-A-REST ANTI-SMOKING LOZENGES

Dr. DeVita had called Dr. Fisher's attention to the sale of tablets of the above name for breaking the smoking habit, and Mr. Plank had procured a sample which was displayed at the meeting. The active ingredient of these tablets, distributed by Eastern Pharmaceutical Co., Jersey City, N. J., was $\frac{1}{28}$ grain lobeline sulfate.

In the discussion that followed, Dr. Bonnycastle

recalled that the gold treatment for alcoholism had worked with some people. The Committee agreed that the tablets were of doubtful value, but could find no legal fault with them.

MAXWELL SMOKELESS CIGARETTE RELAXER

Mr. Plank displayed this product, which consisted of a box containing two imitation cigarettes in holders, each enclosed in a plastic tube. The manufacturer was the Maxwell Cigarette Tube Corporation of New York City; declared ingredients were "Menthol, Natural Oils in special base." The label said: "Smoking Too Much?—draw on a Maxwell Cigarette Relaxer—Cool—Refreshing—Smoothing—Last one Month—Not a cigarette—no tobacco—do not light."

The product was discussed, but no action was taken. Dr. Bonnycastle said that the Germans had a similar device made of rubber for use by non-smokers who did not want to be conspicuous among smokers.

FIRST ON BURNS

Mr. Plank displayed an aerosol dispenser can of this preparation, made by F.O.B. Incorporated of Chicago. Declared ingredients were "oxyquinoline sulfate, liquid petrolatum U.S.P., rosemary oil U.S.P., oil of linseed—oil of geranium;" the label said "Antiseptic—Soothing—Nontoxic—Nonirritant—relieves pain quickly—may be safely applied freely and as often as needed to burn areas—prevents sunburn up to 4 hours."

After some discussion, the Committee voted to recommend that the claims be confined to: "Useful for minor burns."

XANTHINUX

A bottle of these tablets, made by Cole Chemical Co., St. Louis, Missouri, was displayed by Mr. Plank. The ingredient declaration was: "Each tablet contains: Ext. nux vomica 7 mg. (contains 0.5 mg. strychnine), caffeine-theophylline comp. 60 mg." The label carried the statement: "Caution: Federal law prohibits dispensing without prescription. For clinical use." The purpose of these tablets was not stated on the bottle, but an accompanying circular was headed "Stimulation of Male Sexual Functions Cole's Xanthinux An Aphrodisiac."

Prof. Fenney said that he did not think we could do anything about this product because it carried a prescription legend and the doctors who prescribed

it were presumed to know their business; in his opinion the compounds present were not aphrodisiacs. Dr. Bonnycastle remarked that the tablets contained quite a slug of strychnine; he asked Prof. Fenney whether he had encountered prescriptions for this much strychnine, to which Prof. Fenney replied that he had put up a prescription calling for 0.1 grain of strychnine to be taken three times a day. Dr. Bonnycastle said that some people if they repeated such a dose would get hyperreflexes. Prof. Fenney added that the use of strychnine was considered irrational today, and Drs. Bonnycastle and Hart agreed that strychnine was not used nowadays.

On motion of Prof. Fenney seconded by Dr. Bonnycastle, it was voted that it be the opinion of the Committee that the claims in the circular were false because the drugs in "Xanthinux" did not have specific aphrodisiac action in the light of modern therapeutics.

THE NEW MASSACHUSETTS DRUG LAW

Mr. Plank reported that the Massachusetts legislature had passed a substitute for the Federal Durham-Humphrey Amendment which had been interpreted by some Connecticut pharmacists as prohibiting dispensing by physicians. He had written Mr. George Michael, director of the Division of Food and Drugs of the Massachusetts State Department of Health, to find out about this, and Mr. Michael had replied that not only was there nothing in the law prohibiting dispensing by physicians, but the section that had been so interpreted had actually been put in to regularize such dispensing.

Physicians Turn Fees for Treating Plane Crash Victims Into Hospital Fund

Physicians who treated the 37 injured passengers and crew members of the Air France plane crash in Preston City August 3 have pooled all fees for their services in a common fund for purchase of hospital equipment.

The action was taken at a recent meeting of the medical staff of the William Backus Hospital, in Norwich, where victims of the plane disaster were taken. It also was voted to contribute to the fund such fees as may be received by member physicians in any future disaster. The fund will be used to purchase surgical and other equipment as needed at the option of staff members.

FROM OUR EXCHANGES

“Further Observations on Patients with Severe Hypertension Subjected to Adrenal Resection and Sympathectomy” is recorded by Jeffers *et al.* in *Annals of Internal Medicine* (41:2). There were 125 cases in the series studied. Of these, 96 were operated on with the Adson-type sympathectomy and either total or subtotal adrenalectomy. During four years’ observation 23 per cent of the 125 cases have died. The cause of death in more than half of these was a stroke. Extreme impairment of renal function remains the most definite contraindication to operation. Blood pressure response among the 96 survivors following operation is judged to be as follows: excellent, 44 per cent; fair, 24 per cent; poor, 12 per cent; failure, 7 per cent. Improvement in the electrocardiogram, 37 per cent; heart size, 34 per cent, and ocular fundi, 46 per cent. There has been little evidence of progressive vascular damage in these areas following operation. Among the 96 survivors, relief of congestive heart failure, 100 per cent; of angina pectoris, 71 per cent; and of headache, 70 per cent. As measured by phenolsulfophthalein tests and blood ureanitrogen, progressive impairment of renal function may occasionally occur without regard to the postoperative blood pressure response. Unequivalent improvement in renal function has not been found among postoperative patients to date. Of 57 patients having subtotal adrenalectomy, 15 “now require no adrenal cortical replacement therapy.” There is no suggestion that these 15 cases present any evidence of regeneration of the remaining adrenal fragment. Patients subject to total adrenalectomy require cortisone 25 to 50 mg., DCA 2 mg., and sodium chloride 3 to 6 Gm. daily. Among the 96 surviving patients the following sequela have occurred with sufficient frequency to deserve mention: intolerance to cold 19; mild Raynaud’s phenomenon 18; pigmentation of the skin 21; failure of ejaculation in males 15. Of fifteen patients showing persistent and extreme elevation of blood pressure postoperatively, seven have shown improvement while receiving such drugs as protoveratrine, hydralazine and reserpine.

The authors call attention to the fact that this is an experimental approach which cannot at present be recommended as a treatment for hypertension. It cannot be pursued safely without a well integrated

medical, surgical and laboratory team, and close observation throughout the entire postoperative course. As is the case with sympathectomy, it is not possible to predict which patient will respond with improvement nor can it be determined why certain patients with adequate renal function fail to improve after operation.

* * * *

The use of androgenic steroid in aging individuals has aroused interest within the medical profession in recent months. McGavack *et al.* attempt to evaluate the use of four androgens in aging individuals (*Jour. Amer. Geriatric Soc.*, 11:8). Testosterone propionate, 17 methylandrostenediol and stanolone cause retention of nitrogen and potassium, and to some extent of sodium and chloride. They are apparently anabolic in their reaction. The androgen Δ^4 -3, 17-androstenedione had no effect on nitrogen or potassium balance but did cause some retention of sodium and chloride. Each of the four androgens gave the patient a sense of wellbeing with an increase in muscular and mental activity.

* * * *

“The Changing Philosophy of Physician’s Fees” tackles a problem that is at least as old as the medical profession (*N. W. Med.* 53:8). Hyde thinks that three basic freedoms have supported the professional status of the physician: (1) freedom to act solely in the interest of the patient, (2) freedom of selection by the physician and patient, and (3) freedom to set his fee in the traditional manner. The author postulates that the traditional basis for the physician’s fee has been—to each according to his need, from each according to his ability to pay. Sickness insurance, in Dr. Hyde’s opinion, changes this to—from each thrifty person a regular small premium and to the physician a fixed payment. Socialized medicine further changes this to—from the taxpayer an irrelevant tax and to the physician a bureaucrat’s wage. Any impairment of the physician’s freedoms debases his profession to the level of a trade. Hyde thinks that the positive health program of the medical profession is to regain and maintain its status as a profession.

An editorial dealing with the matter of physician’s

fees in the same journal stresses the importance of another campaign of public education. The point emphasized is that the public should be shown the advantage of inquiring about fees before incurring liability. Such a method in the editor's judgment would effectively remove the concern about costs and would eliminate the vast majority of the "complaints now being heard by grievance committees." Such an approach would eliminate the chiseler and the fee-kiter; and preserve Dr. Hyde's third freedom.

* * * *

"Recreation Programs in Industry—Health Asset or Liability" is discussed with approval by Felton in *Industrial Medicine and Surgery* (23:9). There are many reasons for this approval among which may be mentioned man's need for relaxation, the significant differences between participants and non-participants in employee desirability, a greater utilization of full-time directors, and an increase in company-employee and community-company co-operation. The objections to such programs lie in the main in the field of injuries, in inconsistencies in insurance coverage, and in involved proceedings with industrial commissions and courts of appeal.

It is recommended that the individual selected as recreation director be a trained worker in this field with leadership skill; that employees undertaking athletic participation in industrially sponsored recreation programs be physically fit for the activity, that preseason physical examinations be performed on industrial athletes, that all members of teams be trained in first aid, that medical care be provided for those injured by the sponsoring company and that insurance coverage be established to obviate the numerous claims arising from this recreation effort. There is much besides what has been hinted at in this too brief a summary. Perhaps it is enough at this point to suggest that company recreation programs are desirable but that they also have hidden difficulties which should be recognized and planned for.

* * * *

For those doctors interested for any reason in recent advances in cardiac surgery, Hahn's discussion appearing in the August, 1954 issue of the *Rhode Island Medical Journal* is recommended (The 72nd Caleb Fisk Prize Essay, *R. I. Med. Jour.*, XXXVII: 8). It is too long and too detailed an article for an adequate summary. The author points out that the emphasis has been on "extirpative" surgery but that the current trend is to consider methods of

"reconstruction" of existing abnormalities. Out of this concept has come the need of reorienting our thinking in terms of physiological as well as pathological deviations from the norm. Of necessity this new point of view has resulted in a growing curiosity to re-examine old ideas as well as to explore the unknown. A renaissance of endeavor produces new methods, new tools whose total importance may not be realized for years to come.

Surgery in acquired heart disease, in congenital heart disease and cardiac arrest are all summarized in brilliant fashion.

* * * *

Retrolental fibroplasia is the cause of much recent discussion. Breisacher and Lilly have made a statistical survey of cases from Kanawha County Center. From February, 1948 to the time of publication 960 babies were admitted to and treated on their service (*W. Va. Med. Jour.*, 50:9). Retrolental fibroplasia seems to have occurred in 22 per cent of their premature infants. The authors recommend that the pediatrician accept the responsibility of securing the services of an ophthalmologist in every case of prematurity. The pediatrician should inform the parents of occurrence of this disease in premature infants. The ophthalmologist should examine the premature infant properly, carefully and regularly when such service is required by the pediatrician. The ophthalmologist should advise the pediatrician that the initial signs of the disease are or are not present, and should suggest changes in oxygen therapy accordingly. It is the duty of ophthalmologists to make certain that their pediatric colleagues are aware of the role of oxygen in the production of the disease and to insist that the care of the premature infant includes oxygen administration in quantities and of duration sufficient only to sustain life.

* * * *

Sterling is of the opinion that abuse of epinephrine and related compounds in the treatment of asthmatics is not uncommon (*Amer. Prac.*, 5:8). The improper use and contraindications of epinephrine by inhalation and of Aludrin hydrochloride, Isuprel, and Nirisodrin Sulphate by the lingual or nebulization method is described. Clinical symptoms must be carefully observed and adrenergic drugs strictly supervised, and their therapeutic limitations explained to the patient. They should be discontinued if any untoward cardiac, vascular or pulmonary side reactions occur.

Dramamine's® Effect in Vertigo

Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.

Vertigo, according to Swartout, is primarily due* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



The site of Dramamine's action is probably in the labyrinthine structure.

*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP 8:35 (Nov.) 1953.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Newell W. Giles, Darien

President-Elect, Mrs. Norman J. Barker, Collinsville

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The Eleventh Annual Conference of State Presidents, Presidents-Elect and National Committee Chairmen

The Woman's Auxiliary to the American Medical Association

November 16-18, 1954, Drake Hotel, Chicago, Illinois

The theme of the conference, "Leadership in Community Health," was followed through the meeting, both by panel discussions and guest speakers. The conference was opened with greetings from the President, Mrs. George Turner, who introduced Mrs. Mason Lawson, president-elect, who presided. In her report the President, Mrs. Turner, asked for a 10 per cent increase in membership for the year and support for National Foundation for Infantile Paralysis, Crusade for Freedom, and Care packages.

In his address entitled "AMA Round-Up," Dr. Ernest B. Howard, assistant secretary of the American Medical Association, reviewed the various projects being conducted by the AMA in the field of community health and mentioned the twenty-six articles which have appeared in the magazine *This Week*, and the extremely favorable public acceptance as evidenced by the volume of mail commending the articles. The closed medical television programs for doctors only and the program, "Questions and Answers," presented by Dr. Bauer, will soon be available in movie form for presentation to interested groups. The Board of Trustees of the AMA has under consideration a public opinion survey to try to ascertain the feeling of the man in the street towards his personal physician, the local medical society, and medical programs in general. He informed the conference that the student AMA is now a self-supporting and separate organization. The AMA has established a new law department whose help will be available to auxiliaries for drafting constitutions, approving programs and other legal services.

In his talk on school health programs, Dr. W. W. Bauer, director of the Bureau of Health Education, expressed his appreciation to all auxiliary members for the increased distribution of *Today's Health* and for bringing it to the largest circulation in its history. Leading educators and doctors are cooperating in an effort to improve and maintain the health of the school child. He pointed out that the "Bureau of Health Education" has a panel of speakers available for auxiliary health education programs.

Mr. Thomas Hendricks, secretary, Council on Medical Service, AMA, stressed the need for community team spirit to achieve the goal of overall community health.

The Program Panel for community health leadership pointed out the need of a family doctor for every doctor's family, noting that the mortality among doctors is higher than any other professional group. Traffic and home safety were emphasized. Figures were cited to show there were 98,000 accidental deaths last year; of these 30,000 were traffic and 28,000 in the home. Between 30,000 and 50,000 children are crippled every year.

Other activities discussed by the panel members included classes for prenatal care, clothing exchanges, training courses for baby sitters, citizens' day care committees for the school child, a doctors' day program such as is celebrated in some states with memorial tree planting, or a contribution to some project.

Connecticut was ably represented on the Organization Panel by our President, Mrs. Newell W. Giles. Her subject, "How to Maintain Member Interest," suggested that the interest might be stimulated by giving new members the historical background and objectives of the auxiliary, and maintained through the medium of the National Bulletin, and encouraging them to greater activity in community work.

There are 70,000 nonmember doctors' wives in unorganized counties. To start a county auxiliary,

OFFICUS DINGAE!

another name for dingy office — a disease which irritates
tired nerves and mentally depresses patients.

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a dinner meeting with the doctor and his wife was recommended as a preliminary. If the doctor's interest can be enlisted, his wife will certainly cooperate and the rest of the organizational procedure is largely a matter of appointing committees. Every community should have its own student auxiliary. This group now has its own journal and may only need a little encouragement and help to establish a separate unit in your area.

Mr. George Larson, assistant director of the Bureau of Exhibits of the AMA, announced that there is a small scale table exhibit on nurse recruitment available for loan to any community auxiliary for use in high schools.

All members were urged to study the Auxiliary Bulletin, to familiarize themselves with other auxiliaries and their activities, and were particularly requested to make newsletters interesting and include personal touches.

One hundred and three thousand doctors and forty-five thousand dentists have *Today's Health* in their waiting rooms. Every member of the auxiliary should energetically push the further sale of *Today's Health* which is synonymous with community health. It should be available reading for all youth groups, it can be used in school classroom discussions and P.T.A. organizations. In order to further encourage its distribution, the four counties selling the most subscriptions will be given special recognition at the Atlantic City meeting of the AMA. Hundreds of free copies were recently sent to M.D.'s all over the country and this should be followed up with a campaign to get all of these doctors as regular subscribers.

Dr. Walter Martin, president of the AMA, was detained in Washington and unable to attend the luncheon; however, we heard his speech by transcription. He particularly thanked all members for their support of *Today's Health* and the American Medical Education Foundation. He reported that he was busy helping to draft prepaid insurance coverage for the low income families and uninsurables.

Dr. Elmer Hess, president-elect, greeted us on behalf of the AMA and expressed the opinion that all doctors would be glad to lend their support to a plan for taking care of the indigent at the local level and that this was a community rather than a federal problem.

Many and varied ideas for raising funds for AMEF were presented. A Christmas ball in Louisiana

netted \$1,200. In the State of Nevada where they have a fund raising project on a memorial basis, a substantial number of donations were made by lay people. Mr. Hiram Jones, executive secretary of the AMEF, advised that \$1,690,000 was raised last year and that this year's goal of \$2,000,000 could be easily attained through well organized groups and a co-operative effort.

Dr. Austin Smith, chairman of the Board of Directors of the United States Committee of the World Medical Association and editor of its journal, explained his organization's activities as distinguished from the government sponsored World Health Organization of the United Nations and reported that there were now fifty affiliated associations representing every country in the world. Its purpose is to provide a medium through which all physicians can get together on an international level.

The second day of the conference was devoted to auxiliary participation in community health activities. The speakers stressed that public relations is everybody's business and doctors' wives should be well read and informed on the opportunities for community health services. The current pressing need for a solution to the problems presented by our aging population was cited as an example.

Mr. Leo Brown, director, Department of Public Relations, AMA, announced a new publication for presidents and public relations chairmen, entitled, "You Must Teach the Doctors to Practice What They Preach." He emphasized the importance of doctors serving on community health panels and the great need and opportunity for increased health activities in rural areas.

Mr. C. Joseph Stetler, director, Law Department, AMA, explained that 16,000 bills of all kinds were presented to the eighty-third Congress. Of 5,000 enacted into law, no less than 450 of them pertained to medicine. The AMA was specifically interested in 45 bills and 13 of the 14 which they definitely approved were adopted. This year the AMA is vitally interested in the Federal Reinsurance plan and the bill on military dependents' care and has taken the position that the latter should be available only to dependents who are overseas or in remote military installations where other medical services are not available.

Mr. Frank Barton, the new secretary of Civil Defense for the AMA, was introduced and while he commended the auxiliaries for the good job they

were doing, he said that much remained to be accomplished and effort of everybody must be intensified.

In the field of mental health, great stress was put on the problem of juvenile delinquency. Many schools now have trained psychiatrists, realizing that the most urgent need is to get at the source of mental illness. Auxiliary members should serve on P.T.A. and Health Committees. Auxiliary sponsored garden therapy has been successful in a number of mental hospitals.

Dr. Richard Plunkett, secretary, Committee on Mental Health, AMA, reviewed the work of the survey being conducted in order to set up standards for mental hospitals similar to those set up by the Flexner Commission that surveyed the country's medical schools. He told of a hospital in Indiana now offering a "rapid total treatment" for mental illness at a cost of \$1,800 over an eighteen months period as compared with the former method of ten years hospitalization at a cost of \$10,000.

In connection with the nurse recruitment program, it was recommended that nursing scholarships be made available at the State level in addition to county, and the advantages of wide spread publicity in connection with the awarding of the scholarships was pointed out. There are 300 schools for practical nurses in this country. They are doing a very valuable and important work which should be encouraged.

The luncheon meeting on Wednesday was highlighted by talks from the public relations representatives of three large industrial corporations. Significantly, they reported that questionnaires sent out to the families of their employees revealed an overall primary interest in family health.

The rest of the afternoon was devoted to "Mechanics of Smooth Operation." Careful study and greater use of the Handbook was stressed. The names of all officers should be sent to National before August 1 of each year. State auxiliaries should not hesitate to ask National with respect to policy matters. An excellent guide to writing "good minutes" was presented by the constitutional secretary and a copy will be sent to all presidents and presidents elect.

Five State presidents reviewed their particular projects for the past year. They included establishing a homemaker's society to assist the visiting nurse, preparation of a state handbook, a better breakfast campaign, a health poster contest, and medical-hospital press conferences.

On the last day we visited AMA headquarters where we were greeted by Dr. George F. Lull, secretary and general manager, saw a preview of two movies that will later be made available for meetings, and then Mr. Howard Brower, assistant secretary, Council on Medical Service, AMA, discussed voluntary health plans and the recently introduced major medical or so-called catastrophe coverage.

It is hoped that this brief review of the proceedings will convey some small measure of the wealth of interesting material presented by the panels and guest speakers at the conference. For me it was indeed a privilege and a most enjoyable and stimulating experience.

Aileen Barker. President Elect

County News

HARTFORD

On December 3 the Mental Health Committee, under the chairmanship of Mrs. Francis J. Braceland, sponsored a meeting at the Institute of Living. Two films, "Steps of Age" and "The Nation's Mental Health," were shown. Dr. Ludwig M. Frank, assistant clinical director of the Institute of Living, discussed the films and a question and answer period followed the meeting.

The Ways and Means Committee will hold a card party at Centennial Hill hall on Wednesday, January 19, for the benefit of the Educational Fund. Mrs. Asa J. Dion and Mrs. Curtiss B. Hickcox are co-chairmen.

Mrs. Sidney H. Burness, chairman of the Medical and Surgical Relief Committee, reports that already a truckload of medical and surgical supplies (equivalent to the capacity of five station wagons) has been collected from doctors' offices and taken to the New York headquarters.

MIDDLESEX

Members of the Middlesex County Auxiliary have started a collection of toys, games, and books for the new pediatric ward at the Middlesex Memorial Hospital. Mrs. Stanley Alexander is chairman of the project, assisted by Mrs. Louis Soreff, Mrs. Benjamin Shenker, Mrs. Asher Baker, Mrs. Malcom Blakeslee, Mrs. Charles Russman, Mrs. Mark Thumim, and Mrs. Joseph Epstein.

Mrs. C. B. Crampton is representing the Auxiliary in the State Department of Mental Health's project to secure gifts for patients in the Connecticut State Hospital at Middletown. Town chairmen are: Port-

land, Mrs. Asher Baker; Durham, Mrs. Francis Korn; Chester, Mrs. D. Leonard Lieberman; Old Saybrook and Westbrook, Mrs. Aaron Greenberg; Cromwell, Mrs. Walter Nelson; Haddam and Higganum, Mrs. A. W. Thomson, Jr.; East Hampton, Mrs. Norman Gardner; Essex, Mrs. Raymond James. Assisting on the Middletown committee are: Mesdames Vincent Vinci, F. E. Tracy, Andrew Turano, Willard Buckley, Mark Thumim, William Bauer, and Charles Russman.

Mrs. Henry Sherwood, *Today's Health* chairman, reports that more than 50 per cent of Middlesex County quota has been subscribed.

Mrs. Aldo Santiccioli has received contributions from Auxiliary members amounting to \$50.25 for the American Education Foundation Fund.

NEW LONDON

The Woman's Auxiliary to the New London County Medical Association held a board meeting and dessert at the home of Mrs. Gerald Carroll, Tuesday, November 30. Final arrangements for a membership tea to be held at the home of Mrs. Sidney Drobnes, December 7 were made. An effort to include all doctors' wives in an invitation is being made by members on the Hospitality and Membership committees. An Art-Musical program is being planned. All members were sent slips with suggested gift articles for patients in our State mental institutions. We are hoping for a good response to help bring cheer to those less fortunate this Christmas season.

A dinner-dance for the benefit of the American Medical Education Foundation will be planned for the month of February. Windham County is expecting to join us for this gala affair to be held at Lighthouse Inn in New London.

The next board meeting will be held at the home of Mrs. William Wener, Norwich, January 18, 1954.

Connecticut Public Health Association Meeting

The semi-annual meeting of the Connecticut Public Health Association was attended by 200 physicians and public health personnel November 3 at the Connecticut Light and Power Company, in Berlin.

Dr. William H. Upson, of Suffield, president-elect

of the association presided at the all-day conference, which was devoted to education and research in nutrition.

Speakers for the morning program were Dr. John H. Browe, M.D., director of nutrition, Division of Medical Services, New York State Department of Health; Carl R. Fellers, Ph.D., head of the Department of Food Technology, University of Massachusetts; and Mrs. Jeanette Sturmer, home management consultant, Connecticut State Department of Welfare.

Miss Dorothy Wilson, of New Haven, president of the association, presided at a brief business session following luncheon, after which a discussion period on nutrition education was led by Miss Myrtle Babcock, executive director, Waterbury Nutrition Council, and Mrs. Elizabeth Caso, nutritionist, Diabetes Field Research Training Unit, Public Health Service, Boston.

Courses in Medical Journalism

The University of Missouri and the University of Illinois offer courses in medical journalism. The University of Oklahoma has completed plans for a similar course to be offered qualified students.

A workshop course, "Writing for the Medical and Scientific Journals," has been offered by the Washington Square Writing Center of the New York University's division of general education. It began September 30 and will continue until January 27. It will be of special interest to physicians, dentists, scientists, and persons interested in techniques of technical writing and will meet with Mr. Milton L. Zisowitz as instructor.

The May 6, 1954, issue of *The New England Journal of Medicine* carried a fine editorial on the new courses in medical writing and concluded it as follows:

"It is with medical journals and medical publishers that personnel trained in medical writing should find its most constant employment. Further uses for such a training should be with clinics, hospitals and pharmaceutical houses, and it is not too much to hope that eventually a new breed of trained, scientific, discerning, and conscientious medical and scientific reporters may be developed, conscious of their obligations to both the profession they are interpreting and the public they are trying to serve. Then will a millennium have been reached indeed."

SPECIAL NOTICES

HARTFORD HOSPITAL GUEST SPEAKER PROGRAM

Saturdays, 11 A. M., Amphitheater

January 8, 1955, to March 26, 1955

January 8

Edward W. D. Norton, M.D., New York City (with discussion by Byron E. Smith)

Segmental Control of Extraocular Muscles

January 15

Motion picture of Television Symposium, Treatment of Hypertension; American College of Physicians

January 22

Langdon Parsons, M.D., professor of obstetrics and gynecology, Boston University School of Medicine

10 A. M. Evaluation of Surgery for Carcinoma of the Female Pelvis

11 A. M. Abnormal Uterine Bleeding

January 29

E. Myles Standish, M.D., attending dermatologist, Hartford Hospital

Dermatology Kodachrome Presentation

February 5

William Kaufman, M.D., Bridgeport, Connecticut

Dangers of Psychosomatic Diagnosis and Treatment

February 12

William W. L. Glenn, M.D., associate professor of surgery, Yale University School of Medicine

Cardiac Surgery

February 19

George E. Miller, M.D., assistant professor of medicine, University of Buffalo School of Medicine

The Management of Edema

February 26

Thomas I. Hoen, M.D., professor of neurosurgery, New York University-Bellevue Medical Center

Parkinson's Disease

March 5

Oliver Cope, M.D., associate professor of surgery, Harvard Medical School; visiting surgeon, Massachusetts General Hospital

(Subject to be announced)

March 12

Harry Shwachman, M.D., assistant professor of pediatrics, Harvard Medical School; chief of clinical pathology,

Children's Hospital, Boston

Malnutrition in Childhood

March 19

Gustaf E. Lindskog, M.D., professor of surgery, Yale University School of Medicine

Peptic Esophagitis and Its Relationship to Diaphragmatic Hernia

March 26

Benjamin Spector, M.D., professor of anatomy, Tufts College Medical School

The Bio-anatomy of Back Pain

POSTGRADUATE COURSE IN DIABETES AND BASIC METABOLIC PROBLEMS

January 19, 20 and 21, 1955 at Philadelphia

The American Diabetes Association will offer its third Postgraduate Course at The Lankenau Hospital under the directorship of Edward L. Bortz, M.D., associate professor of medicine, Graduate School of Medicine, University of Pennsylvania, and associate professor of medicine, Jefferson Medical College.

Charles H. Best, C.B.E., M.D., F.R.S., co-discoverer of insulin, professor of physiology and director and professor in the Banting and Best Department of Medical Research, University of Toronto, Canada, will highlight the Course by delivering a lecture on "Insulin Deficiency" on Wednesday, January 19, as a feature of that afternoon's session on "The Pathological Physiology of Diabetes." Dr. Best also will serve as chairman of the session on "Normal Metabolism," which is on the agenda for the morning of the opening day's session.

The Wednesday afternoon program, which will be moderated by Henry T. Ricketts, M.D., of Chicago, First Vice-President of the American Diabetes Association will also feature a discussion on "The Mode of Action of Insulin" by William C. Stadie, M.D., professor of research medicine, University of Pennsylvania School of Medicine.

A total of twenty-six lectures and panel discussions have been scheduled for the three-day Course. For the first time in the Postgraduate series, three clinics will be held during the afternoon sessions. During the three-day Course a special tour will be arranged for those desiring to see the new Lankenau Hospital Research Institute.

The Course is open to members of the medical profession. Registration is limited. Fees are \$40 to members, \$75 to non-members. Copies of the Program and registration details may be obtained from J. Richard Connelly, executive director, American Diabetes Association, 1 East 45th Street, New York 17, New York.

The American Academy of General Practice will give 20 hours Postgraduate Credit for the Course.

OBITUARIES

Frederick W. Wersebe, M.D.

1877 - 1954



Frederick W. Wersebe, aged seventy-six, of Washington, Connecticut died in the Grace-New Haven Hospital on May 8, 1954 after a long period of failing health.

Dr. Wersebe was born in New York City, October 24, 1877. He graduated from New York Medical College in 1898 and interned at Bellevue Hospital in New York City and started general practice in Washington, Connecticut, in 1901.

He was a past president of the Litchfield County Medical Association and the Litchfield County Health Officers Association, vice president of the Litchfield County University Club and a member of the State Medical Society. He was a member on the staffs of New Milford and Danbury Hospitals and of the New Milford Hospital Association.

Dr. Wersebe served his town as health officer and medical examiner from 1911 to 1953, and a member of the Board of Education since 1916 and was its chairman for many years.

A civic minded man, he was also moderator of the town meetings, superintendent of the Sunday School of the First Congregational Church, physi-

cian and advisor of the Gunnery School in Washington, Connecticut, and was instrumental in establishing the Visiting Nurse Association and the Washington Chapter of the Red Cross.

Dr. Wersebe had an extensive practice and many friends and the loss of this kind man is keenly felt by all.

Howard G. Stevens, M.D.

William Lee Gills, M.D.

1885 - 1954

When Dr. William Lee Gills died at his home on Banbury Lane, West Hartford, Hartford lost one of its most respected ophthalmologists. Dr. Gills, or "Billy" as most of his colleagues knew him, was born in Bedford, Virginia and received his education in Virginia, graduating from the Randolph Macon College in Ashland, Virginia in 1905, and from Johns Hopkins Medical School in 1912. He interned in the Hartford Hospital from 1912 to 1914 and took his training for his specialty in the Brooklyn Eye and Ear Hospital from 1916 to 1918.

In addition to serving the Hartford Hospital and his private patients for over thirty years without fail, he was also a consultant at the Institute of Living in Hartford.

For thirty years, from 1921 to 1951, he was an active and valuable member of the Hartford Hospital staff in various capacities. At the close of his career he was chairman of the Department of Ophthalmology and a member of the visiting staff. In his early years he practiced ophthalmology and otorhinolaryngology, while in his later years he confined himself to the specialty of ophthalmology.

Dr. Gills was an ardent student of ophthalmology and deeply interested in each and every patient. He had a sympathetic, understanding mind and was constantly searching for new methods of improving the care of ophthalmologic patients. He left a host of friends and patients who deeply respected his ability and judgment. In him were combined to a remarkable degree the attributes which make a great physician. His Virginia charm of manner and his sincerity, coupled with his unostentatious and

serious approach to the problems of life, made him a pillar of strength for his friends, patients, and family. Dr. Gills gave freely of his time to friends, students, interns, and patients alike. He was an outstanding practitioner and teacher by precept, rather than by oratory.

His love for his family, his friends, and his patients, combined with his mental ability and surgical skill, made those who knew him deeply respect his abilities.

During World War II Dr. Gills carried an unusually heavy load in Hartford, due to his own large practice together with the absence of most of the younger ophthalmologists. It was probably this additional load which brought about his cardiac disease and eventually forced his retirement in 1946.

With retirement his activities were greatly limited, but his deep interest in all aspects of life kept him happily occupied, and he was fortunate in finding deep and lasting happiness with his wife, Elsie, whom he married after his internship in the Hartford Hospital and one year of practice in Roanoke, Virginia.

His wife, the former Elsie L. Jones, and his four children, Dorothy L., William L., Jr., Robert Dudley, and Richard R. survive him.

Henry L. Birge, M.D.

Our Anabasis

From a speech by Dr. Alan Gregg at the Annual Dinner of the Association of American Physicians, Atlantic City, New Jersey, May 4, 1954

Men are kept together in contented and effective association mainly by three forces—shared experiences from the past, common beliefs in the present, and mutual hopes and desires for the future. Of these, shared experience is the most philosophical and profound. It is particularly powerful in shaping an individual for the practice of medicine. Not merely the areas of intellectual agreement, but also the frustrations and predicaments lived through together and the individual experiences with patients forge for doctors a common bond.

The events significant to beginners in medicine do not always come in the same order; and the signifi-

cance of a given event or type of event will vary enormously depending on the order and nature of all that has preceded. Certain experiences are cardinal, however, in the formation of the doctor. The first is the choice of medicine as a career; it tends to occur early and the experience of making the choice is unforgettable. In the years preceding entrance into medical school, there comes a memorable day of reassurance from some individual or event that this choice has been a responsible personal decision rather than a dream.

The cadaver which is one's first patient does much of cutting, probing and pulling at the mind of its youthful dissector as he strives desperately for detachment. Few would deny its imprint, whether the accent falls on its stark realism, its unending mystery, its blunt evidence of uniformity, or its power of presenting that great leveller of all men—Death. Ways of thinking change radically when narrative, time sequences and history taking suddenly appear to the student to have as much importance as the skills of measurements and description. With increasing knowledge comes the revelation of how much one ought to know to practice medicine, and in its wake an appreciation of the great integrity required of one who must supervise himself and satisfy himself that his effort is adequate and effective. Presently one must cope with the realization that medicine is not omnipotent, that the doctor's job is to do the best he can under the circumstances and always in the climate of compassion. Discouragement nevertheless arises in clinical training until working with patients brings the refreshing conviction that the practice of medicine is indeed worthwhile. The errors that can be made in diagnosis and treatment, whether by an associate, oneself or a revered idol, can be a shattering experience. Here, particularly, caution and competence, humility and intellectual honesty and integrity prove their worth.

Such are the experiences which bind the profession together. They are the generic experiences characteristic of the doctor's anabasis or way up into medicine. And the deepest bond of all is also the greatest danger and greatest reward in medicine—the First Time a Patient Trusts You—with his life.

Reprinted from *Digest of Neurology and Psychiatry*, July 1954, by permission of the editor.

NEWS

from County Associations

Fairfield

In a report made recently to the Board of Trustees of the Fairfield County Medical Association, it was noted that 10 county physicians had been actively engaged in the 1954 diabetes detection drive in conjunction with the American Diabetes Association and its Connecticut affiliate, the Connecticut Diabetic Association.

Submitted by M. David Deren, Bridgeport, who served as co-chairman for the county with Leonard A. Howard, Cos Cob, the Board was informed that almost all areas of Fairfield County had been covered and that final results have not yet been compiled.

Identified with the detection drive this year were the following: Roger P. Castro, Danbury; George Mandl, Bethel; Joseph S. Bell, Ridgefield; Henry Appelbaum, Wilton; Henry Zalichin, Stamford; James I. Porter, Greenwich; Gabriel A. Saviano, Norwalk; Richard E. Caron, health director of the Town of Fairfield. In the latter town St. Louis Dreypaks were used to secure specimens.

Assisting in the laboratory examination work were a number of medical laboratories and hospitals, Dr. Deren reported, and that for the first time the assistance of the newly established Fairfield County Medical Association office and personnel were called upon to help in the preparation of news stories and radio scripts calling attention to the diabetic detection work in progress.

An "advance" issue of *News Capsule*, a new monthly publication of the Fairfield County Medical Association, was issued in December. The first regular issue of the bulletin will be published this month. Mr. Arnold P. Olson, executive secretary of the Fairfield County Medical Association, is serving as editor, assisted by members of the Public Relations Committee as an editorial advisory board.

In a statement appearing in the "advance" issue, the editorial board made known as part of its credo that no attempt will be made to carry "articles of a scientific bent."

"Other publications coming your way from national, state and special society sources already perform appointed and authoritative roles in many

areas of formal medical reporting," the statement declared in part.

News Capsule will be devoted, the statement declared, to news and events of interest to Fairfield County Medical Association members and professionally related fields and will include programs of local societies and "personals."

Advertising will be carried in issues from January on.

Hartford

The attendance at the semi-annual meeting of Hartford County Medical Association at Manchester in October totalled 166 physicians and guests. Twenty-nine new members were elected to membership at that meeting. This makes our total membership, 907—still the largest in the State.

For the first time on a mass scale the Hartford and Manchester diabetes detection chairmen used the St. Louis Dreypaks as a means of testing for glycosuria. Last year Hartford used the Dreypak experimentally with excellent results. New Britain and Bristol continued to use clinitests and "wet" specimens.

Hartford County Medical Association had a chance to talk about its community services over radio station WTIC in November. The program, a regular weekly broadcast, is sponsored by the National Conference of Christians and Jews. Mr. Frances Ahearn, city editor of the *Hartford Times*, was moderator.

James F. Loftus, recently completing his tour of duty with the Air Force Medical Service, has received an official commendation "for outstanding medical services he has rendered to the population of this base." Another recent service dischargee is Frank H. Horton of Manchester, who has reopened his old office at 935 Main Street. Dr. Horton was in the Navy.

Retiring in October after 33 years as assistant medical director of Travelers Insurance Company was Dr. Euen Van Kleeck.

Diabetes detection chairmen in November were: Norton Chaucer, Hartford; Harold Lehnus and Howard Lockward of Manchester; Sidney Eisenberg of New Britain and Martin I. Hall of Bristol. Marvin B. Day is county chairman.

Wilson F. Smith spoke to a panel at the Hartford Adult School on obesity in October and more recently to the Connecticut Public Health Associa-

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tion on the same subject. John N. Gallivan, East Hartford Health Officer, spoke to the local chapter of the Lions about cancer. John Burns of Hartford talked to local claim examiners about some of the difficulties physicians encounter in handling insurance forms. In Manchester, Dr. Hilda Crosby Standish talked to the PTA group about growth development in children. The Woman's Society of Christian Service of Bristol had as their guest speaker Dr. Paul Tisher of New Britain. He talked about his voluntary service in relief work.

William Lee has been named medical director of Stanley Works, succeeding John S. Irvin who has been director for the company since 1947 and has retired. Dr. Lee has been assistant medical director since January, 1951. Alfred K. Bates has joined the medical staff of the Stanley Works on a part-time basis and will assist Dr. Lee.

Dr. T. Stewart Hamilton has been elected a trustee-at-large of the Connecticut Hospital Association.

In November the Medical and Surgical Relief Committee of the Woman's Auxiliary, headed by Mrs. Sidney H. Burness, mailed out inquiry cards to physicians in the Hartford area to notify them that the Auxiliary will pick up whatever medical supplies

and publications they will donate for overseas free health stations. Although the drive started in November, it is a continuing one throughout the year, Mrs. Burness said. Doctors can either call Mrs. Burness directly at AD 2-1234 or the executive office of HCMA at CH 6-7231, for pick-up service. Physicians can also leave their supplies at the executive office at 242 Trumbull Street. Supplies are delivered to New York where they are trans-shipped overseas by the Red Cross. About 20 per cent of the Hartford doctors have indicated that they have material for the committee, Mrs. Burness reported. Other members of the committee are: Mrs. D. Norman Markley, co-chairman, Mrs. John C. Allen, Mrs. Edward J. Conway, Mrs. A. Elmer Diskan, Mrs. William Furniss, Mrs. Joseph Kalett, Mrs. Richard Kay, Mrs. Michael C. Messina, Mrs. Mark Solomkin and Mrs. James E. Stretch.

Middlesex

Richard Grant and Norman Gardner attended the Clinical Session of the AMA at Miami in early December.

Vincent J. Vinci was in Atlantic City the latter part of November to attend the Clinical Congress of the American College of Surgeons.

NOT ARTHRITIS BUT ARTHRALGIA...

If the patient complaining of aching joints is a woman between 37 and 54 years of age, it is highly possible that she is suffering from arthralgia rather than arthritis.¹ It has been estimated that arthralgia occurs in about 40 per cent of women with estrogen deficiency, and is exceeded in frequency only by symptoms of emotional or vasomotor origin.² In fact, arthralgia may be as indicative of declining ovarian function as the classic menopausal hot flushes.

Arthralgia, however, is just one of a vast number of distressing but ill-defined symptoms that may be precipitated by the loss of estrogen as a "metabolic regulator." Other good examples are insomnia, headache, easy fatigability, and tachypnea.

Because these symptoms sometimes occur years before or even long after cessation of menstruation, they are not always readily associated with estrogen deficiency, and the tendency may be to treat them with medications other than estrogen. Obviously, sedatives and other palliatives cannot be expected to produce a satisfactory response if an estrogen deficiency exists. Only estrogen replacement therapy will correct the basic cause of the disorder.

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1. Greenblatt, R. B., and Kupperman, H. S.: *M. Clin. North America* 30:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: *Endocrine Treatment in General Practice*, New York, Springer Publishing Company, Inc., 1953, p. 225.

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New London

The regular meeting of the New London County Medical Association was held December 2, 1954 at Uncas-on-Thames Sanatorium. The speaker was Charles Solomon, member of the psychiatric staff at Hartford Hospital. His subject was "Psychiatry in the General Hospital." A dinner at Norwich Inn preceded the meeting.

The monthly dinner lecture meeting of the Lawrence and Memorial Hospital was held November 18, 1954. The speaker was Samuel J. Brendler, assistant in neurosurgery, New England Center Hospital and senior instructor in neurosurgery, Tufts College Medical School. His subject was "Head Trauma."

The New London Chapter of the Connecticut Heart Association invited all doctors to attend the monthly cardiovascular lecture December 9, 1954 at the Lawrence and Memorial Hospital, New London. The guest speaker was David Gelfand, Philadelphia. His subject was "The Cardiac Work Classification Unit emphasizing the effect of the Psyche in High Blood Pressure and Coronary Heart Disease."

Hospital Deficits Per Patient

The American Hospital Association reports it cost general hospitals \$21.09 a day last year to care for the average patient whose bill came to \$19.49 a day, the deficit being covered by charitable contributions and government grants. In some high-cost areas such as California and Connecticut, the average daily cost of institutional bed and board is edging close to the \$30 a day mark.

Hospital deficits are swelling as the average deficit per patient is multiplied by an ever growing stream of sick folk making use of hospital facilities. Admissions in 1953 totaled 20,183,827, almost triple the number 20 years ago.

On an average day you can find more people than the combined populations of Boston and Cincinnati (1.3 million) resting in U. S. hospital beds, plus 43,528 newborn infants. The odds are each of these new babies will be confined in a hospital at least four times during its lifetime. When they die, according to Metropolitan Life Insurance Co. figures, it's almost an even money bet they'll expire in a hospital.

Nationally, last year's increase in hospital costs came to more than \$300 million, as total hospital expenses soared to 4.7 billion, qualifying it, some

say, as the nation's fifth largest industry. Payroll expenses alone for the hospitals 1,168,564 full time employees came to close to \$3 billion.

What Excessive Government Spending Means to You

The nation's taxpayers had the wind taken out of their sails recently when the California Taxpayers Association reported that federal, state and local agencies will this year collect some 90 billion dollars in levies.

It's still quite difficult for the average taxpayer to fit himself into a statistic of such magnitude.

But the California association, a private research organization, discovered that it takes a \$4,500-a-year man two hours and 35 minutes of his eight hour day to earn enough to pay his taxes. The levies included are both direct and indirect.

Now this same \$4,500 salaried man works only one hour and 37 minutes daily to pay for food for his family; one hour and 24 minutes for housing costs; 36 minutes for clothing, and 42 minutes for transportation. He also labors 23 minutes for medical care, 20 minutes for recreation, and 23 minutes for other goods and services.

In other words, this typical person works only 26 minutes more a day to provide food and housing for his family than he does to pay his tax load.

The recent federal tax cut, the association said, helped him very little. He managed to save only a few minutes work time.

All of which points to the important need for more economy in government spending.

Nonspecific Vaginitis

Gardner and Dukes reporting in *Science* (120: 3125, Nov. 19, 1954) have isolated a new bacterium that appears to be the causative agent in the vast majority of "nonspecific" vaginitis infections. The investigation includes a clinical and bacteriological study of 91 cases of bacterial vaginitis. A previously unidentified and unclassified organism belonging to genus *Haemophilus* was isolated in 81 of the 91 cases and occurred in pure culture on one or more occasions in 62 of the 81 cases.


From the clinical signs and symptoms the authors believe this organism constitutes a specific disease entity. The organism is extremely fastidious and difficult to isolate by cultural methods. This probably explains why it has escaped previous isolation and identification.




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NEW BOOKS IN REVIEW

SMOKING AND CANCER. A DOCTOR'S REPORT.

By Alton Ochsner, M.D., Past President of American College of Surgeons, of American Cancer Society, and of American Association for Thoracic Surgery. New York: Julian Messner, Inc. 1954. 86 pp. \$2.

Reviewed by STANLEY B. WELD

If you are a cigarette smoker and are not prepared to give up the habit for some more profitable pastime you should not read this book. It contains all the hard, cold facts and is not written by some ambitious statistician but by one of the leading chest surgeons in the United States.

Look at these figures! Fifty years ago primary lung cancer was almost unheard of. From 1939 to 1949 lung cancer deaths rose 144 per cent while all other types of cancer deaths rose only 31 per cent. In 1950 Drs. Evarts Graham and E. L. Wynder discovered that of 605 male lung cancer cases, 96.5 per cent had smoked at least half a pack of cigarettes per day for twenty years. Of these 605 cases in males only eight had been nonsmokers. Along with these startling figures a report appearing in the *Journal AMA* for March 1, 1952 by Dr. Ochsner and collaborators showed that the annual production of cigarettes per capita population (including men, women, and children) increased from 46.3 in 1903 to 2,541 in 1948. In 1953, according to industry estimate, 3,600 cigarettes per person of smoking age were consumed in this country. Dr. Ochsner reports an attempted projection of a possible total of 200,000 smokers with bronchogenic cancer at the present time in this country.

King-size cigarettes, filter cigarettes, denicotinized cigarettes are all discussed. A program for stopping smoking is outlined. The irresponsibility of the cigarette industry through its vicious "health claims" and "paid testimonials" is exposed. Its appropriation of only \$500,000 out of a five and one-half billion dollar business for research in determining the relationship of lung cancer to cigarette smoking is one evidence of how little importance the industry places on this problem.

The effect of smoking on heart disease also comes in for a share in the author's illuminating figures. Finally, Roy Norr, the first lay writer to sound an effective alarm about smoking and cancer, has written this:

"We have become a nation of coughers, sneezers, sniffers, spitters . . . and the greatest consumers of tobacco products in the world. You can spot the dishonest—and honest—doubters of whether smoking has been proved the Great Killer in cancer and heart disease by asking: To whom would they give the benefit of the doubt? To money or to men? To poison or to people?"

It is a startling volume full of irrefutable facts. I doubt if you ever knew the whole story before.

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THE CLINICAL APPLICATION OF RADIOACTIVE ISOTOPES

Present Uses and Some Future Possible Developments

LEE E. FARR, M.D., *Upton, New York*

RADIOACTIVE isotopes in large number have become available for research and medical purposes since the establishment of the Atomic Energy Commission. The application of radioactive isotopes to medical problems has been accelerating during the past 10 years, but today we are still only on the threshold of this development. While in research these isotopes have been avidly seized upon by investigators as most important tools, only a few procedures have thus far attained any general usefulness in clinical medicine. I shall not discuss here the manifold applications of radioactive isotopes in biological and medical research, but shall confine these remarks to uses which have become or show promise of becoming generally applicable in clinical medicine.

Many of the first general applications of radioactive isotopes to medicine were along the lines of development of x-radiation and radium therapy, using powerful gamma emitters as an external source of radiation in the same manner as supervoltage x-ray machines. Physicians now are all more or less familiar with the cobalt radiation unit which utilizes radioactive cobalt as the gamma ray source. Simultaneously, cobalt needles and sutures were developed to permit intense local radiation. Colloidal preparations of phosphorus and gold have been made which can be locally injected. Here the experience with radium needles established the general pattern. These applications of radioactive isotopes are primarily of interest to radiologists and certain surgical specialties using radium.

The pioneer work with radioactive I_{131} in thyroid disease^{1,2} and radioactive P_{32} in leukemia and poly-

The Author: *Medical Director, Brookhaven National Laboratory, Upton, L. I., N. Y.*

SUMMARY

Applications of radioactive isotopes and nuclear reactors to medicine are discussed. The internal administration of radioisotopes in therapy and diagnosis of malignant and nonmalignant disease is briefly outlined. An endeavor has been made to give some perspective of the types of development currently proceeding in this field rather than details of usage in one or two specific instances.

cythemia vera^{3,4} blazed the trail for use of radioactive isotopes as tracers and therapeutic drugs, and opened up a whole new field of development for internal medicine. Today many of the large medical centers, perhaps a majority, provide diagnostic procedures using I_{131} for thyroid disease.⁵ Partial or complete ablation of the thyroid with radioactive iodine is now possible for some patients with hyperthyroidism in whom drug treatment with antithyroid compounds is ineffective and who are poor surgical risks. Polycythemia vera can be brought under effective control with P_{32} .⁶ The early promise of P_{32} in leukemia was not realized, but a measure of usefulness of this isotope in temporarily allaying leukemia has been clearly defined.⁶

These applications were to a degree fortuitous or obvious, and they depended primarily upon the fact of radioactivity rather than its quality. It has become increasingly clear, however, that use of internally administered radioactive isotopes for varying medi-

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cal purposes must be determined in a large measure by the nature of the radiation—whether alpha, beta or gamma; by the energy of the radiation, by the radiological half life of the particular isotope selected and by the physiology of the salt or compound of interest.

Alpha and beta emissions provide particle radiation. Alpha particles are identical with the nucleus of the helium atom. They carry a double positive charge and in body tissues travel only short distances—a few microns—because of their size and consequent frequent collision with other atoms. By virtue of their mass, however, alpha particles provide a type of radiation of high relative biological effectiveness which is usually taken as 20 times that of an equivalent amount of energy provided by beta particles or gamma rays. An alpha particle has roughly 8,000 times the mass of a beta particle.

Beta radiation consists of streams of electrons moving at high velocity. With their lesser size they penetrate into a given atomic population to a very much greater distance than do alpha particles. Thus in tissue they will penetrate up to several millimeters as contrasted with the microns penetrated by the alpha particle. The transfer of energy by beta particles thus is less intense along their path than that of alphas, and their biological efficiency is correspondingly less.

Gamma radiation is comprised of electromagnetic waves similar to visible light or radio waves, but of very short wave length. Their absorption by tissues is small, hence their penetration is great. Further, the changes induced along their path are essentially uniform. Gamma rays are similar to x-rays but are of short wave length.

In addition to the radioactive isotopes which are alpha emitters, beta emitters or gamma emitters, there are those which combine various types of radiation, such as beta-gamma emitters, alpha-gamma emitters, and so forth. Not only is the type of radiation characteristic for each radioactive isotope, but also the energy is characteristic. One element may have several radioactive isotopes, each a beta-gamma emitter, but each emitting beta particles and gamma rays of characteristic but different energies. Thus I_{131} emits beta particles of a maximum energy of 0.6 Mev and gamma rays of a maximum energy of 0.37 Mev, whereas I_{132} , also beta-gamma emitter, yields beta particles of 2.2 Mev and gamma rays of 1.4 Mev maximum energy. Because of these energy differences each of these isotopes can be determined

in the presence of the other by using suitable counters.

In addition to these differences in type of radiation and energy of radiation, each radioactive isotope decays in a characteristic manner. That is, in a given time half of the atoms present will have emitted their radiation and thereby become altered either to a stable form of an element or another radioactive element. This is termed the half life—for each half life that elapses one-half of the potential radioactivity of the element in question will have been dissipated. For example, I_{131} has an eight day half life, while I_{132} has a 2.4 hour half life.

In the application of radioactive isotopes to medicine each of these properties must be taken into account, together with the biological utility or non-utility of the salt or compound concerned. The utilization of radioactive elements because of the unique biological behavior of the chemical element in question depends upon very specific physiological knowledge regarding that element, and such knowledge is generally lacking except for sodium, potassium, calcium and a few other elements and also the relation of iodine to the thyroid gland. At the same time, in many instances the special properties of a particular element can be demonstrated readily only by the use of radioactive tracers and can be demonstrated only as suitable radioactive isotopes become available.

The number of radioactive isotopes is very large. For the 96 common chemical elements there are a total of 1,209 isotopes known. Of these, 281 are stable and 928 are radioactive. Of the 928 radioactive isotopes, 876 are artificially produced. Perhaps a dozen of these at most are used today in medicine. The production of a new isotope in requisite purity both chemical and radiological is often a complicated procedure.

For elements of known physiological behavior, clinical applications have been multiplying rapidly. Examples of this type of development are the use of radioactive sodium or iodinated human albumin to determine circulatory competency in vascular diseases. The latter compound and P_{32} to label red blood cells have been used to determine blood volume.^{7,8}

By merely placing a suitable counter over the anatomical region of interest, following intravenous injection of a suitable radioactive isotope, and comparing the number of counts per minute with a presumed normal region, a measure of the blood flow

in the structure under study can be obtained.^{9,10} Through extensive refinements in method and approach the same basic procedure can be used to determine cardiac output, blood volume and some measure of the flow to various organs.^{11,12} By injection of a small amount of radioactive isotope into the skin the establishment of circulation in tube pedicle skin grafts can be followed, and by means of knowledge of the status of the circulation in the pedicle the time determined precisely at which the next step in the operative procedure can safely be taken.¹³ With knowledge of distribution of some radioactive isotopes it is possible to utilize external counting technique for the diagnosis of brain tumors.^{14,15} In such instances rather extensive counting equipment is necessary to obtain accurate results.¹⁶

In these types of use of a radioactive isotope for diagnostic procedures the only requirement is that the presence of the isotope can be detected readily and simply. The procedures are limited only by the ingenuity of the physician in devising measurements which may have clinical meaning.

Now as it becomes possible to define more precisely the requisite physiological or diagnostic and therapeutic studies, it becomes feasible and practical to select a specific radioactive isotope to do a particular task. Each of these isotopes will have characteristic properties of which advantage is taken for resolution of a given problem. For example, in brain tumor localization: in using a gamma emitter such as iodine-131 incorporated in a suitable carrier, as diiodofluorescein or human serum albumin, many external counts must be performed and final localization may be liable to a not inconsiderable error, particularly if the tumor geometry be unknown. For brain tumors precise localization is of the greatest importance. Now if one chooses a radioactive isotope which results in directional radiation, this uncertainty of position can in considerable degree be resolved. Arsenic-72 is such a radioactive isotope. It is a positron emitter and the positron undergoes an annihilation reaction when it combines with an electron, thereby producing two gamma radiations, emerging at 180° with respect to one another. If a suitable coincidence counter be built, to be sensitive only to these coincident radiations, then the axis of the tumor will lie on the beam axis, and in principle by taking only two measurements at 90° apart, the tumor can be fixed with a degree of certainty. Drs. William H. Sweet and Gordon L. Brownell at the

Massachusetts General Hospital have now developed such a procedure to the point of experimental trial.^{17,18} Here the characteristics of the radiation are selected to be valuable in the measurement required.

Two other examples of the utilization of knowledge regarding radiation characteristics may be cited from studies in progress at Brookhaven National Laboratory. Patients with metastatic ovarian carcinoma frequently develop ascites and pleural effusion which are crippling to the patient. In those instances in which the fluid is not loculated, isotopic radiation from colloidal gold will frequently cause a disappearance of the fluid for a longer or shorter time. In this disease we have explored at Brookhaven the use of chlorine-38, a radioactive beta-gamma emitting isotope of chlorine having a half life of 37.5 minutes. The biological half life of this isotope in the peritoneal or chest cavity is 45 to 50 minutes. Hence we can inject a sodium salt of chlorine-38 into the peritoneal cavity, where by virtue of the relationship existing between radiological and biological half life most of its energy will be dissipated and only a negligible amount will escape to the blood stream to radiate the hematopoietic system. In similar fashion at Brookhaven we have used the gas krypton-87, which is a pure beta emitter with a half life of 78 minutes. In this instance the low solubility of the gas in body fluids militates against its disappearance from the cavity to which it is administered. Another example which I shall cite takes advantage of knowledge of the physiology of the isotope together with its radiological characteristics and the ease of preparation in a reactor. Dr. L. S. Maynard of the Medical Department at Brookhaven has observed that manganese-56 injected intravenously was very quickly removed from the blood stream and accumulated transiently in the liver and pancreas. By selection of the 2.6 hour half life radioisotope of manganese it is possible to obtain delivery of most of the radiation while the isotope is in these two organs. Later it is excreted into the intestinal tract in the bile and pancreatic juices. The distribution of the isotope is at such rate that in a man 300 millicuries injected intravenously may provide a radiation dose of 600 rep to the liver and over 1300 rep to the pancreas, while only 60 rep is delivered to the blood. Here the physiological behavior and radiological properties suggest this isotope might prove useful in alleviation of primary pancreatic and hepatic malignancies. Indeed on this basis we have already carried out exploratory

therapy with this isotope with results which encourage one to pursue the problem further.¹⁹

When one gives a radioactive isotope internally for therapy it is necessary to depend on the blood to carry the isotope to the desired target. This results unavoidably in a degree of radiation to the blood which in some instances, as in the treatment of metastatic thyroid carcinoma, may be the limiting factor in dosage. In other cases the time during which the radioactive isotope remains in the target site may be short in relation to its radiological half life and hence result in unwanted radiation of other structures. To obviate some of these difficulties and to gain certain other advantages we are exploring a procedure in which the radioisotope is made in situ in the diseased tissue, and in which its radiological half life is so short as to preclude transport to any other region of the body. This is carried out by administering intravenously to a patient a compound containing a stable isotope of an element which will very readily capture a thermal neutron and by virtue of this capture will become radioactive. The radioactive decay of the element is almost instantaneous—of the order of one thousand millionth of a second—and results in heavy particle radiation of the surrounding area. The element is so chosen that the range of radiation is limited to a distance about equivalent to the diameter of one cell, and therefore only the objective tissue segments are radiated. To this procedure we have given the name neutron capture therapy. The neutron exposures can be limited to the desired body region by designing the proper facility in a nuclear reactor or pile. The selectivity of the tissue in question is obtained by having precise knowledge of the rate of distribution of the capture element throughout various body tissues and taking advantage of the differences in rates in tissues of different quality, so that the neutron beam is applied when the capture element is at a relative maximum in the malignancy and at a minimum in the surrounding normal structures. With the very limited radiation range and the instantaneous decay, the effects are limited to the tumor mass. To the study of this type of application of transfer rates in body structures we have given the term selective kinetics.²⁰

Since February, 1951, the procedure of neutron capture therapy has now been used in an experimental way in the treatment of 15 patients with glioblastoma multiforme.^{21,22} Boron has been used as the capture element. We must use the rarer stable

isotope of mass 10, since boron of mass 11 does not capture neutrons readily nor does it emit heavy particles as the result of this capture. The boron is synthesized into borax and injected intravenously. Exactly 10 minutes later the head is placed over a port in the nuclear reactor from which thermal neutrons escape in large number and the exposure continues for 20 minutes.

The published results on ten patients were not definitive but have been encouraging. Recently we have been able to increase over 10 times the number of thermal neutrons which can be brought into the body structures, and are hopeful that this may prove to be adequate for more definitive results.²³ The application of these principles of selective kinetics and neutron capture therapy is not limited to brain tumors but as yet we have not obtained sufficient data to begin clinical trials on malignancies occurring elsewhere.

In this discussion I have not given details of usage of isotopes in clinical medicine, but have endeavored to give some perspective of the types of development currently proceeding. Many more applications could not be mentioned because of their number and limited time. There can be no question that the future will bring more and more simplified and practical uses of these intriguing tools. These applications will help enormously to elucidate both common and complicated diagnostic problems and to evaluate classical therapeutic procedures in various disease states, as well as to provide therapy itself in malignancies and perhaps in some other disease states not yet under control. Profitable development will come as the profession as a whole learns about the possibilities inherent in this field. The members must help equip themselves both materially and with knowledge to fructify and ripen the efforts of those men in the laboratories and clinics now devoting a large portion of their efforts to exploration of uses of radioactive isotopes and the machines of nuclear science in experimental and clinical medicine.

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IRRITABLE COLON SYNDROME

A Critical Evaluation of the Results of Therapy With Particular Reference to a Method of Accelerating the Rate of Improvement

MILTON M. LIEBERTHAL, M.D., *Bridgeport*

PATIENTS with the irritable colon syndrome are often the most miserable people in the internist's waiting room. In addition, they are frequently the most numerous. It is imperative, therefore, that any therapeutic regimen recommended for such a group stand up under close scrutiny, if only because of the large numbers of patients involved. Strangely enough, such critical evaluations of treatment do not appear in the recent literature, and it therefore seems important to record a current experience with a series of irritable colon cases in which the methods of treatment described below were responsible for a satisfactory result in 76.7 per cent of one hundred and twenty-nine cases.

THE PROBLEM

There has long been general agreement in regard to the nature of the irritable colon syndrome.^{1,2} It is considered to be an abnormality of the motor and/or secretory functions of the colon caused by psychogenic factors^{3,4} mediated by the sympathetic and parasympathetic centers, generally with evidence of parasympathetic preponderance.⁵ The colon thus afflicted may be seen by sigmoidoscopy, radiography, or both, to be irritable and spastic. Its mucous membrane is frequently edematous, reddened, and granular, and excessive amounts of mucus may pass from it. Such a colon may be responsible for abnormalities in bowel function and for a great variety of other discomforts⁶ located principally in the region of the abdomen, but also, though less often, in the chest and back as well. These discomforts may even occur in patterns that strongly suggest the presence of organic disease in the abdomen and, since the irritable colon syndrome is responsible for the symptoms in about 45 per cent of the patients who present themselves with gastrointestinal complaints, all agree it constitutes one of the most frequent and trying diagnostic problems the physician has to face.

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SUMMARY

One hundred and twenty-nine cases of the Irritable Colon Syndrome meeting strict diagnostic criteria have been analyzed and the results of treatment determined with special emphasis on the objective findings. With proper attention to the psychogenic abnormalities and the use of the best symptomatic therapy available, satisfactory results were obtained in 76.7 per cent of these patients.

There is considerable agreement also concerning the proper method of treatment of this condition.⁷ First and foremost, an adequate approach to the psychic and emotional factors is invariably deemed necessary. This is usually accompanied by a revision of the diet so that there are provided well balanced meals, low in irritating residue, taken at regular times, and supplemented by adequate fluid intake. In addition, small doses of sedatives and full therapeutic doses of antispasmodics are prescribed. There is, perhaps, less agreement concerning the measures to be used to establish normal bowel function, but the desirability of accomplishing this is widely accepted.

However, despite this general agreement in regard to the nature and method of treatment of the irritable colon syndrome, and despite the fact that large numbers of patients are apparently being treated with similar methods in many different cities, there is a paucity of analyses of the results of such treatment.⁸

This is understandable. For one thing, much of the success achieved in untying the psychic knots of an individual patient depends on the personality of the physician. This is too great a variable when

comparative studies are attempted, especially in the larger medical centers where many different physicians may participate in the treatment of individual patients. Furthermore, objective evidence of improvement is frequently difficult to obtain, and subjective evidence is even more difficult to assess against a fixed scale of values. Nevertheless, some idea of the efficiency of a treatment program for the irritable colon syndrome can be obtained if (1) the variables in the personality factor are stabilized by limiting the analysis of cases to those which have been treated by one physician, and (2) by selecting such standards, against which the patient's improvement is to be measured, that subjective personal interpretation is reduced to a minimum and objective evidence is emphasized. This study is an attempt to do just that.

THE CASES, METHODS, MATERIALS, AND CRITERIA
CASES

One hundred and twenty-nine personally treated patients, consisting of all those who had diarrhea due to the irritable colon syndrome, were selected for analysis out of a total series of 351 irritable colon cases. All 129 of these selected cases had had previous attacks of abdominal pain or distress and considered their complaints to be chronic (of at least a year's duration). All of them had had diarrhea as their major type of bowel function. Sixty-five had had diarrhea only, consisting of more than one distinctly loose stool every day. One patient had had as many as twelve stools a day, and one as few as two. The remainder ranged between four and eight stools a day, 46 patients having five or six.

Sixty-four patients had had occasional periods of constipation scattered through their more general pattern of diarrhea. These periods consisted of more than one day of either hard stool or no stool at all. However, the longest such period recalled by any patient in this series was four days; the greatest frequency of occurrence of these constipated periods in any patient in this series was no more often than once in every eight days; and the greatest percentage of time occupied by such periods of constipation in any patient in this series was 34 per cent. Hence, in all these patients too, diarrhea was their major type of bowel function. And it is these cases with diarrhea predominating that were chosen from the total series for analysis rather than the remaining 222 cases with only constipation. This was done because it was felt that the diarrhea group

better represented the more severe form of the irritable colon syndrome and tended to eliminate the patient who was simply bowel conscious, the patient who was a pure laxative-habit problem, or the patient whose constipation stemmed from laziness, poor toilet facilities, etc. In other words, there was less chance of error in the diagnosis of the irritable colon syndrome in those patients who suffered from diarrhea.

All of the selected cases presented psychogenic causes for their diseased state but none of them was a victim of bizarre or obviously incurable stigmata, such as a repulsive physical deformity or irreversible notoriety. It was felt that such incurable stigmata invariably imposed on the patient a psychological adjustment too great to achieve, and that the inclusion of such cases would only alter the statistical results of this study far out of proportion to the frequency of their occurrence in the general irritable colon population.

Although a detailed analysis of the psychogenic causes involved in this series of 129 cases is beyond the scope of this paper, it is of some interest to classify briefly the nature of the problems which beset these patients. Table 1 lists them in the order of their frequency of occurrence.

TABLE 1

Financial difficulties	54
Marital difficulties	41
Difficulties with relatives.....	27
Dissatisfaction with life's work.....	19
"Aloneness" of older age groups.....	16
Miscellaneous frustrations	14
Apprehension over children.....	8
Total	179*

*46 patients had 2 or more of the above problems.

All of the selected cases resided in the metropolitan area of Bridgeport, Connecticut, and all of them occupied a reasonably acceptable niche in the social-economic patterns of this region. They ranged in age from 20 years to 76 years, the majority being in the third to fifth decades. There were 76 females and 53 males.

METHODS

The patients were all studied by means of a complete history and physical examination, including fluoroscopy. The laboratory studies included a blood count, urinalysis, serology, gastric analysis, and stool examinations. Successful sigmoidoscopies were per-

formed in every case. The x-ray studies consisted of a gastrointestinal series, barium enema, and cholecystogram (in those patients whose gall bladder had not been previously removed). Such other diagnostic procedures as electrocardiograms, basal metabolic rate determinations, and serum amylase levels were used whenever they seemed indicated by any symptoms that suggested the possibility of organic disease. None of these patients was found to have any significant organic disease. On the other hand, all of them showed colonic spasm and irritability by sigmoidoscopy, and 86 showed the same findings by radiography, too. Forty had obvious mucus in their stools, and all had the colonic mucous membrane changes seen in the irritable colon syndrome.

MATERIALS

All of these patients were treated in substantially the same way, and remained under observation for at least a year. They were each made to understand the mechanisms by which their bowel symptoms arose. They were reassured about the absence of organic disease. They were given ample opportunity to discuss their difficulties freely and were encouraged to solve their problems or to adjust to those situations which could not be changed. They were taught to eat, sleep, and exercise regularly, and how to fit these requirements into their regular schedule of work or responsibility in such a fashion that their lives did not have to be completely changed nor they themselves branded as invalids.

They were all placed on a low residue diet and encouraged to eat as large amounts of the permitted foods as they could. Milk was allowed in only very small quantities. Those who were underweight or who gave a history of dietary insufficiency were also given a multivitamin preparation.

Each patient received an antispasmodic, usually trasantine, but occasionally belladonna or atropine and, rarely, bentyll hydrochloride. Small doses of phenobarbital were given, in combination with the antispasmodic medication whenever possible. None of the "pain killing" drugs was used. Heat to the abdomen, by means of a heating pad or hot soak bath, was occasionally prescribed for acute pain.

Bowel function was controlled by the use of a hydrophilic colloid derived from blond psyllium seed (*Plantago ovata*). The particular preparation used was Konsyl which is composed of virtually 100 per cent hemicelluloses and no sugars or other dispersing agents. The Konsyl was given in doses of a teaspoon-

ful in four to six ounces of water, two to three times per day. The rationale behind the use of this material was based upon the theoretical desirability of substituting a non irritating bulk in place of an irritating bulk (lignin and cellulose). Foods containing the latter had been eliminated from the diet because of the objective evidence of irritation of the colonic mucous membrane present in these cases. For it has been shown⁹ that the colon resumes a more normal peristaltic pattern¹⁰ when it is supplied with a stool of medium soft consistency of sufficient bulk,¹¹ especially if the indigestible portion of that bulk consists primarily of hemicellulose.¹² It is true that Konsyl is generally considered to be a laxative, but it was reasoned that if the abnormal bowel function in the irritable colon syndrome is truly the result of psychogenic stimuli, mediated through the autonomic nervous system, then supplying non irritating bulk in the stool should be equally effective in each case, regardless of whether the abnormality of bowel function consists of diarrhea or constipation. Actually, treating this series of 129 irritable colon cases with diarrhea with the same hydrophilic colloid used to treat another group of 222 constipated cases produced such strikingly similar results in both groups that the above line of reasoning now seems more than justified.

CRITERIA

The results of therapy were judged by both subjective and objective findings. The subjective response was considered to be "satisfactory" when the patient finally had no complaints and had remained symptom free, even after being placed on a regular diet of his own choice without medication, and had been allowed to indulge in his normal program of activities, and when this state of improvement had persisted for a longer period of time than ever had occurred spontaneously before.

Bowel movements were considered "satisfactory" when one or two formed stools occurred daily, at regular times, unaccompanied by any discomfort.

The objective response was considered "satisfactory" when the colonic abnormalities visualized sigmoidoscopically were no longer present on repeat examination, and when the irritability demonstrated radiographically did not show on subsequent fluoroscopy and films.

The general result was considered "satisfactory" only when both the subjective and objective responses were "satisfactory."

Since no scale could be devised to measure reliably degrees of partial improvement, such partial improvement was classified, along with the no improvement group, as "unsatisfactory."

THE RESULTS

There were 129 cases treated according to the above described regimen. There was no significant difference in the results obtained between the group which had had diarrhea and the group which had had diarrhea with periods of constipation.

Ninety-nine patients (76.7 per cent) achieved a satisfactory general result. Fifty-one of these patients were male.

The occurrence of this satisfactory result was not related to the duration of the symptoms before treatment nor to the age of the patient.

Thirty patients (23.3 per cent) had an unsatisfactory result, as the term "unsatisfactory" is understood in this study. It is interesting to note that 28 of these 30 patients were female. This is a much greater preponderance of the female sex than occurred in the series as a whole. There was no relationship between the unsatisfactory result and either the age of the patient or the duration of symptoms before treatment was instituted.

However, 26 of the 30 patients who had such "unsatisfactory" general results showed some partial improvement in one way or another.

For instance, six of the 30 patients who had an unsatisfactory general result did achieve normal bowel function. Nevertheless, all six continued to have intermittent abdominal distress in spite of continuing on treatment. In none of the six was there improvement in the sigmoidoscopic appearance of the colon and rectum.

Twenty of the 30 patients with unsatisfactory general results reported some lessening of symptoms, either in severity or frequency, in spite of no significant improvement in bowel habits. However, no objective evidence of improvement ever appeared in this group and the abnormal sigmoidoscopic and radiographic appearance remained unchanged.

Four patients had no improvement at all. Their symptoms remained unchanged and their bowel movements continued to be abnormal. Strangely enough, there was no relationship between this unhappy result and either the ages of the patients or the duration of symptoms before treatment was

begun. However, it was thought that the approach to the emotional factors was least effective in this group.

Table 2 records the incidence of positive sigmoidoscopic findings, roentgen evidence of irritability of the colon, and the occurrence of mucus in the stools before and after treatment.

TABLE 2
CASES WITH DIARRHEA ONLY

CASES 65	BEFORE TREATMENT	AFTER TREATMENT	
		SATISFACTORY	UNSATISFACTORY
		RESULT 51	RESULT 14
Positive sigmoidoscopies	65	0	14
Positive barium enema			
Distal spasm	22	0	1
General spasm	23	0	8
Negative barium enema	20	51	5
Mucus in stool	18	0	1

CASES WITH DIARRHEA AND CONSTIPATION

CASES 64	BEFORE TREATMENT	AFTER TREATMENT	
		SATISFACTORY	UNSATISFACTORY
		RESULT 48	RESULT 16
Positive sigmoidoscopies	64	0	16
Positive barium enema			
Distal spasm	21	0	6
General spasm	20	0	5
Negative barium enema	23	48	5
Mucus in stools	22	0	9

An interesting opportunity for a controlled study of the value of the hydrophilic colloid used in the treatment arose in this series of 129 cases. The first 43 cases did not receive Konsyl as part of their early treatment. The remaining 86 cases were given Konsyl right from the beginning. After three months, the first 43 cases received Konsyl also. This difference in the treatment timetable did not reflect itself in the final results, since both groups contributed equally, percentagewise, to the satisfactory general result group. However, in calculating the rate of improvement it was found that the patients who were given Konsyl reached their point of maximum subjective improvement much faster than those who had not received it. For instance, of the 43 patients who did not receive Konsyl right from the beginning, 33 ultimately fell into the satisfactory general result group. Yet none of these 33 patients had been rendered symptom free by the end of their

three month period of no-Konsyl treatment, even though most of them had improved somewhat. By contrast, of the 86 patients who received Konsyl right from the start of treatment, 60 of which ultimately fell into the satisfactory general result group, 58 had been rendered symptom free by the end of 22 days. This showed that when improvement occurred, it occurred much more rapidly if Konsyl was being used as part of the treatment.

THE CONCLUSIONS

It is possible, by means of the treatment program outline above, to achieve a 76.7 per cent satisfactory result in cases of the irritable colon syndrome with diarrhea.

Of the patients who achieve an unsatisfactory result, most are apt to be female—28 out of 30 in this series.

The mere re-establishment of normal bowel function does not guarantee a satisfactory general result. Six patients achieved satisfactory bowel movements without enjoying maximum improvement.

Conversely, patients may improve symptomatically to a limited degree without any corresponding improvement in bowel function. Twenty patients in this series fell into such a category.

The factors of age and duration of symptoms do not influence the ultimate results of treatment. This was universally true in this series.

The use of the hydrophilic colloid, Konsyl, greatly accelerates the rate of improvement in symptoms.

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ESOPHAGEAL STRICTURE

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"Caustic strictures" of the esophagus have decreased in incidence since the days when a can of lye was commonly found on the household kitchen shelf. Nevertheless, caustic burns still occur, and the resultant esophageal strictures still pose problems in management, as illustrated in the following case:

This 14 year old, white, diabetic girl was admitted to the Pediatric Service of the New Haven Hospital for the first time on June 14, 1953, complaining of persistent epigastric discomfort following the inadvertent swallowing (3½ hours before) of a sodium hyroxide Clinitest* tablet, thinking it was aspirin. Shortly after swallowing the tablet she had noticed some burning in the throat and epigastrium for which the mother gave her some Alka Seltzer. After discovering that the child had swallowed a Clinitest tablet, the mother gave her lemon juice, olive oil and finally vinegar. The patient vomited this mixture. The vomitus did not appear bloody.

Physical examination was essentially negative on admission as were routine laboratory findings except for a severe glycosuria. An esophagogram done on the day after admission revealed no evidence of ulceration or other pathology and the patient was discharged home on a soft diet.

About three days after discharge the patient noted the first onset of dysphagia for solid foods. These tended to stick and sometimes had to be regurgitated. This difficulty increased until July 11 when she was readmitted to the hospital. At this time an esophagogram revealed a definite stricture of the esophagus about 1 inch in length at about the level of the sixth thoracic vertebra. There appeared to be an ulcer extending out about 1 cm. posteriorly from the lumen of the stricture, while the distal esophagus was nicely distended with barium, showing no evidence of stricture. Under general anesthesia esophagoscopy was done for the first time on July 17. At a level 25 cm. below the upper incisors a stricture was found, the surface puckered and was superficially abraded. Numbers 9 F and 11 F bougies were passed. Repeat dilatation under general anesthesia was done one week later to a No. 22 F bougie, and the patient was discharged.

Between July 30 and October 1, the patient was admitted to the ENT service on five different occasions for esophageal dilation under general anesthesia. On October 17 she was admitted to the Pediatric Service because of an episode of

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SUMMARY

Stricture of the esophagus offers many difficulties in management, and these are illustrated in this case of a caustic stricture in a diabetic child. Resection of the area of stricture and reanastomosis has been found feasible in cases of well localized stricture and was found particularly helpful in the handling of this case.

diabetic acidosis which had been at least accentuated by the fact that she had difficulty in maintaining an adequate oral intake. Blood chemistries were as follows: CO₂—8.8; chlorides—98.4 mEq; sodium—132 mEq; potassium—4.8 mEq; sugar—362 mgm. per cent. Urine sugar and acetone were both 4 plus. She was discharged after 4 days in the hospital with her diabetes again well under control.

Three weeks later the patient was admitted to the ENT service unable to swallow anything, including liquids, since the previous day after a piece of meat lodged in her esophagus. Esophagoscopy performed the following day failed to reveal any foreign body and dilations were again carried out, using bougies No. 16—22F.

Three weeks later following a routine esophagoscopy and dilatation she awoke from her anesthesia complaining of considerable pain in the right upper quadrant, right lower chest and retrosternal area. The temperature 2 hours after the procedure was 100° F. (rectal). The abdomen showed some spasm in the right upper quadrant but no deep or rebound tenderness. There was no evident suprasternal emphysema. X-ray of the chest and barium swallow appeared normal, but the white blood count was 20,000 and there was 90 per cent polymorphonuclear leucocytosis. In view of these findings it appeared that sufficient trauma had been associated with the esophageal dilation to produce some mediastinitis. Accordingly the patient was given 600,000

*Used for checking sugar content of urine

units of penicillin and 0.5 Gm. of streptomycin per day. The temperature did not exceed 100.4 degrees (rectally) over the ensuing week. It was then decided to perform a segmental resection of the stenosed portion of the esophagus. This was performed on December 12, 1953.

At operation the chest was entered through the right 5th rib bed. A few adhesions were found in the paravertebral region just inferior to the azygos vein at the approximate level of the stricture. This was the only evidence of any recent trauma or mediastinitis. The azygos vein was divided, and the mediastinal pleura was opened throughout the length of the esophagus after injecting novocaine around the right vagus nerve. The esophagus was mobilized throughout the whole length of the chest. The vagi, both right and left, with their arborizing branches were not divided, except for a few minor arborizations, but were freed up from the esophagus over a distance of several centimeters to allow separate division of the esophagus and also to allow eventual approximation of the esophageal segments without tension. A Levine tube introduced into the proximal esophagus encountered an obstruction at the level of the 6th dorsal vertebra, the level of the stricture by esophagogram. There was an increased rubbery denseness palpable at this level, so that the level of the stricture appeared to be well identified. The esophagus was resected for a distance of about 1 cm. above and below this area, and in the process it was noted that this area did contain a considerable amount of dense fibrous tissue. An end to end anastomosis was then performed using 2 rows of interrupted silk sutures. Penicillin 500,000 U. and streptomycin 0.5 Gm. were placed in the pleural cavity before closure. The patient was maintained on continuous gastric and pleural cavity suction for about 36 hours, when both tubes were removed. There was evidence of good intestinal peristalsis on the first postoperative day. She was given nothing by mouth except for an occasional sip of water until the eighth postoperative day. On the twelfth postoperative day an esophagogram revealed a good passageway at the site of the previous stricture and the patient was discharged home. She had been maintained on penicillin and streptomycin until the ninth postoperative day. The highest temperature was 101° F. (rectally) on the second postoperative day.

For two days after discharge the patient had no difficulty swallowing. The following day, fifteen days after operation, she noticed some difficulty swallowing solid food. This dysphagia became progressively worse, requiring a shift to liquid diet three weeks after operation. At this time a #18 French mercury dilator did not pass the operated site and she was admitted for dilation under general anesthesia. The area of anastomosis was visualized through the esophagoscope, and was easily dilated to #36 French. The following day she swallowed a #30 French dilator without difficulty, and continued this daily at home. She swallowed quite well after this procedure but gradually developed dysphagia again over a three week interval until only a #24 French dilator was advanced. The following day a #30 French mercury dilator was swallowed easily and she was given this to use daily at home.

This dilator was gradually increased to a #34 French, used daily at home. She has continued to pass this dilator herself every few days and has had no further difficulty in taking a regular diet.

CONCLUSION

It was considered inadvisable to subject the patient to repeated general anesthetics for dilatations which had to be done at frequent intervals to be effective. For this reason, and because the stricture was well localized, surgery was carried out and proved successful. Postoperative dilatation is now relatively simple and assures lasting success.

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ACNE VULGARIS

ACNE VULGARIS is one of the commonest and most misunderstood of the skin eruptions. Descriptively, it is a chronic inflammatory disorder of the pilosebaceous follicles, confined to the skin of the face, back and shoulders and characterized by papules, pustules, comedones, cysts and nodules. Etiologically its nature is less clear. In the words of a standard dermatology text: "Acne is due to changes in the consistency of the sebaceous secretion; the increased activity of the endocrine system—the gonads in particular—affects the secretions of the sebaceous glands."¹ Until the disease can be clarified in terms of altered biochemical functions, its cause and treatment must be essentially empirical.

PRESENT STUDY

Clinical management of acne usually includes a consideration of several body systems beside the skin.² The present study is based on the hypothesis that three systems, endocrine, hematopoietic and digestive are involved in the pathological physiology. Therefore, systemic treatment was directed toward the correction of recognizable defects and the maintenance of proper balance among the systems. In addition, local treatment included the use of topical estrogens, based on the reported efficacy of such therapy.³

Fifty patients with acne vulgaris, ranging in age from 12 to 42 years, were studied in this series. Forty-three were female and seven male. Approximately 84 per cent were 25 years of age or under. The length of treatment averaged 18 months and ranged from 12 weeks to 7 years. Complete medical histories and physical examinations were accomplished initially for every patient. Blood counts, urinalyses and basal metabolic rate determinations were done routinely, with exceptions as noted. The basal metabolic rates were less than zero in 35 of the 50 patients. These varied from minus 1 to minus 41 and averaged minus 12. Only five patients had read-

Systemic and Topical Treatment

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SUMMARY

A regimen of constitutional and local treatment for acne vulgaris described.

Excellent results were observed in the majority of 50 patients in whom nutritional, hormonal and hematinic measures of therapy were combined with topical treatment of the affected skin.

Regular use of skin-cleansing agent Acidolate,^(R) and of an alcoholic solution of the synthetic estrogen Dienestrol proved to be a most affective form of topical treatment.

ings above zero, ranging from plus 1 to plus 38 and averaging plus 7.8. The basal metabolic rate was measured at least twice in all but 10 patients who failed to have the test made for various reasons. Most of the patients also had mild degrees of anemia that was hardly normochromic. Occasional blood smears, however, showed some degree of hyperchromaticity.

TREATMENT

DIET

Every patient was questioned about the quality and quantity of his daily diet. All patients were skin tested for the presence of food sensitivity, and foods causing positive skin reactions were interdicted. Hypoallergenic, no-spice, low-fat diets were routinely prescribed. Additions or deletions from the standard diet were frequently necessary, depending upon results of the skin tests and analysis of the patient's normal habits of eating. A sample of the standard diet follows:

ALL FOODS COOKED

MEATS	CEREALS AND FLOUR	VEGETABLES	FRUITS	FISH
Beef	Wheat	Potatoes	Apples	Salmon
Chicken	Rye	Carrots	Pears	Haddock
Lamb	Oats	String beans	Peaches	Tuna
Pork	Rice	Peas	Prunes	
Ham	Corn	Squash	*Bananas (ripe)	
Bacon		Cauliflower	*Bananas (flaked)	
		Cabbage		
		Spinach		
BEVERAGES				
Postum	Eggs			Salt
Tea	cooked			Sugar
Coffee	in cooking			Butter
	Milk			Vanilla
*Raw	Cheese			

Dietary supplements were supplied in approximately the following daily amounts:

Vitamin A	10,000 units
Vitamin D	1,000 units
Riboflavin	5 mgs.
Thiamine	5 mgs.
Pyridoxine hydrochloride	2 mgs.
Calcium pantothenate	10 mgs.
Nicotinamide	30 mgs.
Ascorbic acid	100 mgs.
Vitamin B ₁₂	12 mcg.
Ferrous sulfate	100-200 mg.

HORMONAL TREATMENT

Thirty-eight of the 50 patients took thyroid extract in doses ranging from ¼ to 5 grains daily. Systemic administration of female sex hormones (estrogens and progesterone) was indicated in some cases. When the latter hormones were employed, they were given rhythmically with the menstrual cycle to improve menstrual dysfunction.

LOCAL TREATMENT

Topical agents were used by all of the patients. When the study was first begun in 1947, routine care of the skin included the following: The affected areas were cleansed with soap and warm water at bed time and allowed to dry. Lotio alba or a natural estrogen cream was applied and allowed to remain on the skin overnight. This was removed in the morning and a sulphur-resorcinol ointment applied.

In 1952, an alcoholic solution of Dienestrol* was made available to the author and was substituted for

*Solution of Dienestrol (5 mg. per cc.) in 70 per cent alcohol was supplied by White Laboratories, Inc., Kenilworth, N. J.

the natural estrogen cream. The topical routine then prescribed was as follows: The face was cleansed with Acidolate^(R) and warm water at bed time and allowed to dry. Dienestrol solution was then applied to the affected area and allowed to dry. In the presence of excessive secretion the treatment was repeated in the morning. If excessive dryness resulted, daily applications of a medicinal grade of cold cream for a few days usually corrected the dryness.

GENERAL MEASURES

In all cases general hygienic measures were emphasized and recommended. For example, eight hours of undisturbed rest, a regular time for bowel evacuation, daily baths, and regular meals taken in a pleasant atmosphere were all stressed. Diseases unrelated to acne were corrected where feasible.

RESULTS

Within a period of several weeks the skin of all patients showed improved texture and decreased oiliness. Usually the acute inflammatory processes of the affected skin subsided promptly and no or relatively few lesions appeared. More chronic lesions gradually diminished or disappeared. In all, 40 patients showed excellent improvement and 10 showed moderate improvement.

With continuation of treatment, especially among the cooperative patients, recurrences were infrequent. Those patients who, by their own admission, adhered only partially to the prescribed diets suffered the most recurrences. It was noted also that such recurrences were not as severe in the patients who regularly used the topical solution of Dienestrol but were otherwise uncooperative.

The following two case reports are representative:

CASE 1

M. T., 12 years, female. First seen December 1, 1952. Complaints: rash on the face and chin for six months. Loss of interest in school work.

Physical examination: General size and development normal for her age. She is somewhat withdrawn and defensive. Ht. 62½", wt. 114 lbs., B.P. 120/70, pulse 75, regular. The skin of the face shows an extreme pustulopapular rash, with numerous comedones. There is a moderate amount of scarring. Fingernails are bitten short. The thyroid appears normal. Patellar reflexes hyporeactive bilateral.

Hb. 11.5 Gm., R.B.C. 3.55, urinalysis negative, B.M.R. minus 41.

Treatment:

(1) Diet: On the basis of strong positive skin tests, condiments, strawberries and eggs were removed from her diet.

(2) Thyroid, grain ¼ daily, was prescribed. The daily dose of thyroid was gradually increased over a 12 month period to 5 grains.

(3) Vitamins and ferrous sulfate were advised in the amounts already mentioned.

(4) Care of the skin: Acidolate^(R) and alcoholic solution of Dienestrol were used at night according to the previously described routine.



CASE 1
Before

Results: One year after beginning treatment this patient measured 64½" and weighed 120 lbs. Her acne disappeared almost entirely and she regained her sense of good humor and interest in her work and play. The first photograph shows her at the time of her first examination; the second, one year later.

CASE 2

M. E., 20 years, female. First seen on May 19, 1946. Complaints: rash on the face; skin irritation on nose; palpitation of the heart; weakness.

Past history: Painful and irregular menstrual periods from onset in 1939. Six weeks before her first visit she had suffered a severe shock when she returned to her home and found her father unconscious. This incident precipitated an anxiety state and a mild facial eruption became aggravated.

Physical examination: General development appears normal. Ht. 65¾", wt. 120 lbs., B.P. 105/75, pulse 100 and regular, heart apparently normal. There is a moderately severe papulopustular acne eruption on the face and shoulders. Some scarring is present on the face and back.

Hb. 11.3 Gm., R.B.C. 3.49, urine negative, B.M.R. plus 38. Skin tests showed plus 3 and 4 reactions for tomatoes, pork, chocolate, peaches and cherries.



CASE 1
After



CASE 2
Before



CASE 2
After (warts removed photographically)

Treatment:

(1) Diet—tomatoes, pork, chocolate, peaches and cherries were deleted from the standard diet.

(2) Antithyroid medications were prescribed along with phenobarbital until the B.M.R. adjusted to plus 12 where it remained during treatment.

(3) Polyvitamins and ferrous sulfate daily.

(4) Liver extract parenterally thrice weekly.

(5) Topical treatment: Begun in 1946 and carried on through 1951 with only moderate success. Early treatment included the use of superfatted soap and lotio alba at night and resorcinol-sulphur ointment in the morning. When an estrogen cream became available in 1950, this was substituted for the lotia alba.

In January 1953, Acidolate^(R) was substituted for superfatted soap as the skin cleansing agent, followed by the application of Dienestrol solution to the affected parts.

Results: This patient's skin improved moderately on the prescribed regimen for a period of five years. After January 1953, when topical Dienestrol was first employed, improvement was rapid and more complete. Her skin cleared almost entirely and has remained greatly improved to date. Photograph No. 1 was taken in January 1953; photograph No. 2 in March, 1954, 14 months later.

DISCUSSION

The pathological basis of acne is unknown but probably is associated with disturbances of interrelated functions among the hematopoietic, endocrine and digestive systems. Effective treatment, as described in this study, consisted of a combination of systemic and local therapeutic approaches. Correction of dysfunctions of the hematopoietic, endocrine and digestive systems; improvement of faulty general hygiene; and finally, topical treatment of the affected skin have produced good results in the author's practice during the past seven years.

Of the topical agents employed, the most effective proved to be a solution of Dienestrol in alcohol. It was applied once or twice each day after the affected skin had been cleansed with Acidolate.^(R) Excessive dryness of the treated areas was complained of by three patients, and this was promptly corrected by the morning application of a suitable face cream for several days. One case of mild gynecomastia

occurred in a young boy who mistakenly applied the Dienestrol solution every 2 hours, during his waking hours, for several days. No other unusual reactions resulting from treatment were encountered.

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ACNE SCARS

Dermal Abrasion of Scars by Rotary Steel Brushes

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SUMMARY

During the past three years the author has used the refrigeration-dermal-abrasion-rotary steel brush method for the correction of pitted scars from acne, smallpox, traumas, and pigmentations, and have obtained excellent cosmetic results, much superior to all the other recognized methods which have been used, including the so-called sandpaper surgery. The rotary brush technique is comparatively simple and may be done in the physician's office as hospitalization is not necessary. Complete healing takes place in about 10 days and the procedure is painless throughout.

FOR many years skin defects such as acne scars have been treated by various methods including sandpaper surgery, scarification, electrodesiccation, use of solid carbon dioxides, and topical applications of trichloroacetic acid and phenol.¹⁻⁵ A method of dermal abrasion of the skin by rotary stainless steel wire brushes and heatless stones has been developed and used successfully in removing pitted acne scars, scars resulting from trauma, and unsightly pigmentations.^{6-8,9}

This planing method of surgical abrasion of the skin is done as an office procedure, simply and painlessly, and does not require hospitalization. Blemishes have been removed as the result of one or more surgical planings and the cosmetic results have been good to excellent. In more than 200 cases treated by this method of dermal abrasion, effective results have been attained in every case, although some cases of severe pitted scars may require two or three planings for best results.

TECHNIC

Prior to the actual surgical planing, the area to be treated is chilled for about twenty minutes with an ice pack containing 5 per cent propylene glycol in water. The skin is then cleansed with alcohol and the specific areas to be planed are outlined with tincture of Zephiran or mercurochrome. If a facial area is to be treated, the scalp is covered, the eyelids are

protected with a petroleum ointment, and cotton plugs are placed in the aural and nasal orifices.

To complete the freezing of the skin, ethyl chloride or "Freon" is sprayed on the area to be treated. This solidifying of the area to be treated takes from thirty to sixty seconds and presents a firm, even surface for the operator. Using a stainless steel wire brush, driven by an electric motor capable of 12,000 or more revolutions per minute, the scars to be treated are abraded down into the corium (Figure 1). Brushes of various sizes are used, depend-

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FIGURE 1

Rotary stainless steel wire brush used for dermal abrasion of pitted acne scars

ing on the size of the area to be treated. The revolutions of the brush are controlled by a foot pedal.

Bleeding may occur before the planing procedure is completed, in which case reapplication of ethyl chloride or the "Freon" will check the bleeding and return the area to its desired rigidity. To check the bleeding which will occur following the operation, dry sterile gauze is applied with pressure for about twenty minutes, following which the treated areas are dressed with a sterile petrolatum dressing covered with gauze. Patients return to the office each day for a week or ten days to have the dressings changed.

For most cases, one surgical planing will be sufficient to produce the cosmetic result desired; however, further planings may be given if necessary in six weeks or later.

It is important to note that certain cases when there were acne lesions still present, the acne disappeared following the dermal abrasion.

Figure 2 (A and B) shows the results of one dermal abrasion by steel brush. An excellent cosmetic result was obtained.

CONCLUSION

Of all methods used for the correction of pitted acne scars, dermal abrasion by the use of rotary stainless steel brushes and abrasive stones has proved most efficient. The fact that this is an office procedure with no hospitalization required has been of value to the patient and to the physician.



FIGURE 2

(A) Patient with pitted acne scars before dermal abrasion of pitted acne scars



FIGURE 2

(B) Good cosmetic result after single planing of scarred areas

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THE SURGICAL TREATMENT OF INTRACTABLE ANGINA

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FOR the sake of clarity, I would like to review a few of the fundamentals concerning angina and in this way be sure that we have a mutual understanding of terms insofar as this discussion is concerned.

ANGINA AND CORONARY DISEASE

Angina and coronary disease are terms which have been used interchangeably and synonymously and yet they can be entirely unrelated. Angina may occur with or without coronary disease being present and coronary disease may occur with or without angina. Coronary artery spasm alone can result in angina. Angina and even myocardial infarction from acute hemorrhage have been reported and the necropsy studies revealed a normal coronary system with no evidence of previous disease.¹

Another study of 300 autopsies on United States battle casualties in Korea, in whom there had been no clinical symptoms of coronary disease, showed gross evidence of coronary disease in 77.3 per cent. The disease process varied from fibrous thickening to complete occlusion of one or more of the major vessels, and the average age of these soldiers was 22.1 years.² This would indicate that the pathology of coronary disease begins long before the symptoms

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SUMMARY

Angina is the result of primary or secondary myocardial ischemia and may occur with or without the presence of coronary artery disease. There are two general methods of relieving intractable angina. The first is by neurosurgical means, and the second is by revascularizing procedures. The various methods of each are reviewed.

appear, and that the disease begins earlier in life than is usually appreciated.

MYOCARDIAL ISCHEMIA

Angina, coronary insufficiency, and myocardial infarction all have the common denominator of myocardial ischemia and this may be primary or secondary. Myocardial ischemia is primary when there is organic disease of the coronary arteries which prevents a sufficient delivery of blood to the

myocardium. Myocardial ischemia is secondary when the insufficient blood supply is due to factors other than organic coronary disease, such as is seen in myocardial hypertrophy resulting from hypertensive disease, or in rheumatic heart disease in which the myocardium or valves are affected.

The myocardium depends mainly upon the coronary arteries for its blood supply; however, it does receive an additional supply from small vessels around the pulmonary artery, and around the superior and inferior venae cavae, from the pericardium and aorta. This additional blood supply constitutes the "residual myocardial circulation" when the coronary arteries have become occluded. The "residual myocardial circulation" is capable of tremendous growth and expansion under proper stimulation. This growth and development may be the most important factor in all of the present methods of myocardial revascularization and has not been sufficiently emphasized.

SURGICAL RELIEF OF INTRACTABLE ANGINA

There are two general methods of relieving intractable angina. The first is by neurosurgical means, which relieves the pain of a limited area, has no direct effect upon myocardial ischemia or the course of the disease. The second is by revascularization procedures which correct the myocardial ischemia by furnishing an additional blood supply.

The neurosurgical points of attack³ are upon the vasomotor nerves to prevent spasm of the coronary arteries. This is of dubious value. The second point of attack is upon the motor accelerator nerves by interrupting impulses which speed the heart beyond its already limited capacity for work. This results in a slowing of the heart rate only during rest. The third and most logical point of attack is by interruption of the pain pathways which is accomplished by blocking the upper four or five thoracic sympathetic ganglia with alcohol injections, or by the surgical removal of these same ganglia, or by posterior rhizotomy.

THORACIC GANGLIONECTOMY

It is of interest to consider briefly each of these methods. Thoracic ganglionectomy carries a mortality of 14 per cent and therefore should be used only in medium risk patients. It gives partial relief of pain in 50 per cent and complete relief of pain in 30 per cent. Seventeen per cent of the patients are unimproved and there is a late recurrence of pain in 25 per cent. Posterior rhizotomy enables a bi-

lateral denervation to be done in one stage, but is a formidable procedure. Although the mortality is only 10 per cent, it should be limited to good risk patients. This operation gives excellent relief of chest and arm pains but little relief of neck and jaw pains. Paravertebral alcohol injection requires an accurate knowledge of neuroanatomy, a technical skill and constant practice to avoid painful and at times serious complications, and should be limited to poor risk patients. It gives partial and complete relief in 64 per cent, although the enduring good results are only 23 per cent. Recurrence of the pain within three to six months occurs in 35 per cent and 28 per cent of the cases are unsatisfactory. We feel that the neurosurgical procedures are useful where revascularization cannot be tolerated or is unsatisfactory, or in terminal cases.

MYOCARDIAL REVASCULARIZATION

Myocardial revascularization should mean not only an increase in the amount of blood delivered to the myocardium but an improvement in the distribution of this blood to the muscle fibers. Surgical revascularization of the myocardium depends upon two principles for its effects: first, the use of extracardiac tissues or vascular anastomoses (grafts), and second, the stimulation and development of the residual myocardial circulation. The extracardiac tissues must have or be capable of producing a satisfactory collateral blood supply while the vascular grafts bring blood directly to the coronary system. Stimulation of the residual myocardial circulation occurs to a certain extent in all of the operations upon the heart as a result of the irritation produced by the surgical trauma. When the purpose of the operation is mainly to produce an irritation, the effect upon the residual myocardial circulation is more intense and prolonged, and the greater the intensity of the irritation and the more prolonged it is, the greater the stimulation to the development of the residual myocardial circulation. If the irritation could be permanent, then the stimulation is continuous.

The varieties of tissue grafts used now are simple and granulomatous. The simple fixation or grafting of such tissues as muscle, omentum, fat, pericardium, and lung has been done for many years, but the long time effect has been so negligible that this procedure has been abandoned. The granulomatous graft, however, takes advantage of two principles and utilizes an extracardiac supply of blood from

the graft, as well as stimulating the residual myocardial circulation by producing an irritation of the myocardial surface resulting in the formation of a granulomata. This is probably the best method of revascularizing the myocardium.

One vascular graft consists of an anastomosis⁴ between the aorta and the coronary vein. A section of either vein or artery⁵ may serve as the anastomotic bridge between the aorta and the coronary sinus. This produces a reversal of the coronary venous flow and attempts to arterialize the coronary venous system. It is likely that the transplanted vessel, or some part of the coronary venous system, will eventually become thrombosed, and the good effect of the operation will be entirely dependent upon the amount of stimulation to the residual myocardial circulation. Another vascular graft⁶ consists of burying the proximal end of the severed internal mammary artery in the substance of the ventricular myocardium, in the belief that this buried artery will form new vascular buds and channels which will communicate with the coronary artery branches. The clinical results in some cases seem promising, although the experimental results are conflicting.⁷

Cardiopericardiopexy (for the sake of convenience, hereafter referred to as cardiopexy) means the fixation or grafting of the pericardium on to the surface of the myocardium. The pericardium is used as the source of extracardiac collateral circulation because it has an abundant blood supply of its own.⁸ When performed according to our method, cardiopexy revascularizes the myocardium by stimulating the residual myocardial circulation as well as utilizing a granulomatous tissue graft. It is a simple operation requiring about 30 minutes for its performance and does not of itself carry much of a morbidity or mortality. For these reasons it can be used on handicapped patients, some of whom might be unsuitable for other types of operations.

TECHNIQUE OF CARDIOPEXY

An incision about three inches long is made parallel to the long axis and directly over the fifth costochondral cartilage on the left side. The incision is carried down to the perichondrium, which is stripped from the cartilage, both on its anterior and posterior surface, and the cartilage is removed from the lateral surface of the sternum outward to its junction with the fifth rib. The posterior layer of perichondrium is split lengthwise, exposing the in-

ternal mammary vessels. These vessels are retracted mesially by a small retractor of appropriate size, thus protecting and withdrawing them from the operative field. The thin fibers of the transverse sterni muscle are split or cut, exposing the pericardium. At this site the pleural reflexion does not usually appear in the wound; however, extreme care should be used in peeling off this pleural reflexion to the outer angle of the wound if it should be present. The pericardium is now elevated with hemostats and a small incision is made parallel to the skin incision. Observation is made of the quantity of pericardial fluid present, and the approximate pressure of this fluid can be judged by the height to which the fluid column rises with each cardiac diastole. The pericardial incision is enlarged to approximately two inches in length and one or two stay sutures of absorbable catgut are taken in each side of the pericardial cut edge. The pericardial fluid is now aspirated as completely as possible so that no residual fluid remains to wash all the talc to a dependent site within the pericardial sac, thus producing a localized rather than generalized irritant reaction of the pericardium and myocardium.

Depending upon the size of the heart, approximately two to four level teaspoonfuls (4 to 8 Gm.) of dry sterile magnesium silicate (U.S.P. Talc) is now distributed over the surfaces of the myocardium inside the pericardial sac. This distributed powder should cover as wide an area as possible and be thin enough not to appear caked. We have occasionally used as much as six teaspoonfuls, but a smaller amount will usually suffice. In our earlier cases, we instilled the powder by means of an atomizer but now prefer to use a small metal spatula or trowel. The pericardium is now loosely closed and the chest wall structures are closed in anatomical layers without drainage.

The powdered magnesium silicate particles are not absorbed or removed by the lymphocytes or phagocytes. It is a definite irritant and produces a strong inflammatory reaction which spreads from the myocardium and pericardium to the mediastinal structures and is attended by a severe hyperemia. This irritation is a desirable stimulant to the further development of the residual myocardial circulation, and since the irritant is not removed, it is a permanent source of stimulation. The reaction is attended by the formation of a granuloma on the surface of the myocardium and the pericardium becomes adherent in this area.

There are no untoward effects of this reaction such as the formation of scar tissue, or the development of constrictive pericarditis. The granulomatous area acts as a bridge for the communication of intra- and extracardiac blood vessels. We have been able to secure autopsies on patients for as long a period as 10 years after cardiopexy and have found no deviation of the features mentioned above.

INDICATIONS FOR CARDIOPEXY

The indications for cardiopexy are prophylactic, actual and palliative. The prophylactic use would occur in a young individual with coronary disease attended by a controllable angina. There is no valvular involvement and no hypertension, and there has been no previous infarction. The palliative use of cardiopexy would occur in an older individual with intractable angina. There may or may not be some valvular involvement and hypertension may or may not be present. The patients have such a decreased tolerance for physical exertion that they are almost completely incapacitated. Between these two extremes lies the greatest usefulness of cardiopexy.

CONTRAINDICATIONS

The contraindications to cardiopexy are local and general. Advanced renal or hepatic disease, or extreme debility from any cause would constitute too great a hazard. Patients with myocardial infarctions within three months, or infarctions that appear to be still active after a longer period of time, are to be excluded from operation. Intractable and uncontrollable congestive failure is also a contraindication.

RESULTS

Over a period of 16 years we have performed more than 150 cardiopexies. Two years ago we made a 14 year follow-up study of the first 50 cases who survived the operation.^{9,10} In this group there were 57 patients, of whom 7 died following the operation. Of the remaining patients, 66 per cent were still living at the time of this study. There were 37 males and 13 females, the youngest of whom was 35 and the oldest was 68. The average duration of symptoms before operation was three and a half years. Of the 17 patients who died later after leaving the hospital, the average length of life was five years following cardiopexy.

There are no satisfactory objective tests to determine the degree of improvement following cardiopexy, so we have formulated a series of subjective tests to determine the degree of rehabilitation. They are: (1) decrease in anginal pain; (2) ability to perform daily duties; (3) increase in exercise tolerance; and (4) a return to their former or at least some gainful occupation. We have divided the patients into three groups. Those who were improved less than 50 per cent were considered poor results, and there were only 10 per cent who fell into this group. Those who were improved more than 50 per cent were considered good results, and 90 per cent fell into this group. A third group who were improved more than 75 per cent were considered excellent results, and 40 per cent of the patients fell into this last group.

By comparison with other methods of myocardial revascularization, cardiopexy appears to be the simplest and has the lowest morbidity and mortality rate. It has the widest application in the handicapped group of patients and the results are as good, if not better, than with any other method.

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HERPES ZOSTER OF THE FACE AND NECK

With Paralysis, Earache, Dizziness and Nausea
(J. Ramsay Hunt Syndrome)CHARLES SHEARD, JR., M.D., and EDWARD A. FELDER, M.D., *Stamford*

IN the recent past, idiopathic facial paralysis, or Bell's palsy, has responded satisfactorily to Cortisone treatment.^{1,2,3} Also reports have indicated that the pain and severity of herpes zoster may be relieved greatly by ACTH,^{4,5} some observers favoring the intravenous route. One case of herpes zoster has been described⁶ where Cortisone did not help, though ACTH did, and in 1953⁷ several cases of herpes zoster developed in patients under treatment with ACTH and Cortisone. All this would indicate the value of ACTH and Cortisone in preventing painful symptomatology and sequelae in herpes zoster, though it would indicate they are unable to prevent the development of the disease.

Having been called to see a patient rapidly developing facial paralysis, dizziness, and earache of the left ear along with herpes zoster of the left side of the face and neck, we were very much interested in the possibilities of therapy with ACTH. This was especially so, in view of the study by Costello and Scott⁸ who were able to show that the average duration of the residual paralysis of the facial nerve was slightly less than six months. The two patients reported by these observers developed their facial nerve paralysis after the third week of their herpes zoster.

CASE REPORT

Mrs. A. B., a 43 year old housewife, was well until December 13, 1953 when she was seen by one of us (E. A. F.) complaining of severe pain in the left side of the neck. Physical examination at that time revealed tenderness of the superior portion of the left trapezius and the left sternocleidomastoid muscles. No lesions were present and turning of the head accentuated the pain. A diagnosis of myositis was made and the patient was treated with infra-red heat and other symptomatic therapy. On December 15 she was seen again, and at this time small vesicles were beginning to appear along the distribution of the mandibular division of the fifth cranial nerve and in the distribution of the 2nd, 3rd, and possible 4th cervical nerves. She was treated at home with Aureomycin orally (250 mgm. q.i.d.) aspirin, codeine, and bed rest. She continued to complain of great

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SUMMARY

Herpes zoster with involvement of motor elements, (facial nerve paralysis), is reported, with almost total recovery of the paralysis following six days of ACTH therapy, such recovery having remained permanent for six months. It is hoped this report may be of help in treating similar cases, though the danger of drawing unwarranted conclusions from single cases is fully realized. The reports of long-standing sequelae, as well as the average duration of those paralyses that get better eventually, in other cases of Ramsay Hunt syndrome reported in the literature, lead one to believe that this method of treatment offers considerable hope of greatly relieving the paralysis. Paucity of material for study precludes paired comparisons. This case is therefore reported as an example of a successfully treated Ramsay Hunt syndrome.

discomfort and the lesions became more aggravated, so various preparations such as calamine with phenol and colloidion paint were applied in an attempt to provide a relief. She was given Protamide by injection without avail for discomfort.

She was seen by the second observer (C. S.) on December 19, on the seventh day of her illness. At this time she complained of earache, pain in the jaw, mild dizziness, and some nausea. She exhibited drooping of the left side of the face, with "ironing out of the facial expression," inability to close the left eyelids, tearing of the left eye, and her mouth was pulled down towards the normal side. There was inability to "whistle," obviously a facial nerve paralysis. In addition,

of course, there was a very severe vesicular, almost blistering herpes zoster involving the left mandibular division of the fifth cranial nerve, and the 2nd and 3rd (possibly some of the 4th) cervical nerves, extending from the midline posteriorly, around and over the clavicle to the midline anteriorly. There was extreme hyperesthesia over the involved areas and the tip of the helix was red and the eardrum was injected and red.

The patient was admitted to the hospital on December 19 and received 120 units of ACTH Gel i.m., using the 40 units per cc. HP preparation and the Aureomycin, aspirin, and codeine as before. Meningeal involvement was feared, and perhaps some comfort was afforded by continuing the antibiotic. Demerol was needed to control the pain the first night. The helix continued to show erythema but no vesiculation. Thereafter the patient received 40 units of ACTH Gel daily i.m. until December 26, after which time she received 40 units i.m. every other day and on December 30 this too was discontinued.

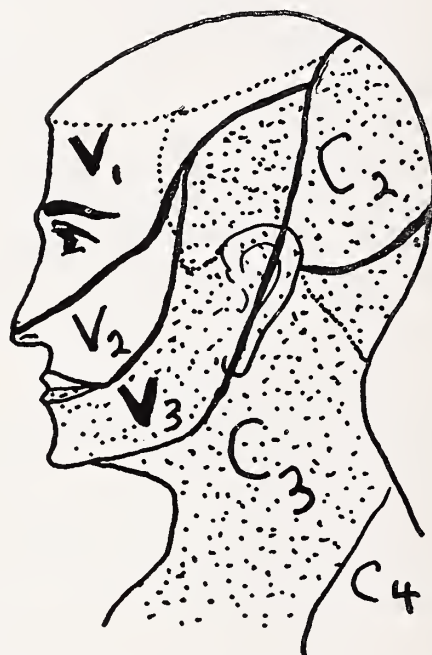
The response was dramatic. After twelve hours, the drooping of the left side of the face and the left eye was slightly reduced. The pain was still present and the eardrum was still injected. On the evening of December 20, there was 25 per cent return of power and by December 22 there was no facial distortion and the patient could blink her eye and close her eyelid, and was able to hold her muscles of expression firm against pressure by the examining physician. By December 24 she was almost normal, and two days later was completely recovered as far as the motor symptoms and signs were concerned, though the skin lesions were still mildly tender and only moderately healed. She was discharged on December 30 and was followed at monthly intervals, last being observed on June 28 at which time all sequelae were pleasantly and totally absent. An interesting note is that her son developed chickenpox on December 29 and was clear by January 27.

DISCUSSION

Herpes zoster is an inflammatory process probably occurring in the dorsal root ganglion of the spinal nerve, or the cranial sensory nerve ganglion, caused by a neurotropic and epidermotropic virus. The attack may be preceded by (and followed by) pain, and manifests itself by the occurrence of cutaneous vesicles with or without erythema, sometimes necrosis, usually in a linear distribution usually following the dermatome for that particular sensory nerve or group of nerves. It is also unilateral and it is thought that the cutaneous lesions arise because of the peripheral migration of the virus from the ganglionic focus to the epithelial cells. A virus has been shown to be present in the vesicles. It is commonly thought that with the exception of herpes zoster of the ophthalmic nerve, herpes zoster of the other cranial nerves is rarely diagnosed though it occurs often.⁹

The case reported here is interesting in that the

maxillary division of the trigeminal nerve is not involved as was the case in the two patients reported by Costello and Scott,⁸ though the mandibular division is involved. There was also some involvement of the external auditory canal with pain in the eardrum at onset, and erythema of the drum shortly after onset, along with dizziness and later nausea; also, of course, facial paralysis. It would appear from a study of the anatomy involved¹⁰ that the mandibular division of the trigeminal nerve communicates with the 7th nerve by way of the lingual nerve (which is a general sensory nerve for the floor of the mouth and anterior two-thirds of the tongue)



Dermatomes of the face, neck and scalp. The stippled area represents those affected in the reported patient.

and is joined in the infratemporal fossa by the chorda tympani (which is partly secretory for the salivary glands and partly sensory for taste in the anterior two-thirds of the tongue). The chorda tympani's sensory cell station is the geniculate ganglion of the 7th nerve, while its secretory fibres are preganglionic parasympathetic fibres whose cell station is the sub-mandibular ganglion. The otic ganglion, which is the size of a pinhead, is connected to the mandibular division of the trigeminal nerve and has sensory roots in the lesser superficial petrosal nerve (7th and 9th cranial nerves) and communicates with the chorda tympani and auriculotemporal nerve. Thus there is another channel of communication here. The auriculotemporal nerve supplies the outer surface of

the eardrum, and the anterior wall of the external auditory canal and the jawjoint; as well as having secretory fibres to the parotid gland.

Therefore it would appear that the facial nerve has predominantly motor fibres, but also contains sensory fibres and the methods of communication are numerous. It can communicate with the fifth, eighth, ninth, and tenth, and cervical nerves. It should be remembered that the first cervical nerve has no cutaneous fibres. Thus there are many potential channels for the extension of a neuritis, or a herpes zoster.

Many views have been expressed as to just what is meant by the Ramsay Hunt syndrome.¹¹ Hunt's insistence that the geniculate ganglion is the chief site of involvement has been challenged by Denny-Brown¹² who showed pathologically that this is by no means always the case. However, regardless of the localization of the pathologic process, the clinical evidence of facial nerve paralysis, along with earache and dizziness in herpes zoster of the trigeminal and cervical nerves, is so striking as to warrant attention.

It is apparent that there are many pathways by which the virus can travel from sensory to motor nerves to produce paralysis. Tschiasnyk has remarked on this situation also¹³ as has Lathrop.¹⁴

When the facial nerve is involved, paralysis results, and when the cochlear division of the acoustic nerve is involved, then deafness and tinnitus may occur; as also when the vestibular portion of the eighth nerve is affected, then nausea and vomiting may occur. In any one patient, one or more nerves may be involved, including the third, ninth, and tenth cranial nerves. The changes that occur are usually reversible, though often there are permanent residua, and convalescence may be long, and require cor-

rective plastic surgery. Therefore, any therapy offering a method of preventing the permanent irreversible complications of herpes zoster, is worthy of trial.

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MYOCARDIAL INFARCTION

A review of the cases at St. Vincent's Hospital, Bridgeport, Connecticut, for the year 1952

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THIS paper constitutes a review of patients with myocardial infarction admitted to St. Vincent's Hospital, Bridgeport, Connecticut for a one year period. It was felt that some information would be gained from studying patients in a large active community hospital where private and general service patients are treated. One hundred and twenty-one cases are reviewed of which 88 were men and 33 were women, which confirms the more frequent occurrence of this disease in males. The overall mortality rate for the series was 34.7 per cent. Twenty-seven of the males and fifteen of the females expired. Wooten and Kyser¹ found an overall mortality in their group of 39.5 per cent. Hauss and his colleagues² report an overall mortality rate of 46 per cent. Rathe³ in a series of 274 cases found that 20 per cent of his patients died in the first month. Bland and White⁴ mention a 44 per cent mortality rate in 86 patients. Thus our mortality rate is in line with these authors. However, Connors and Halt⁵ report a mortality rate of only 16 per cent. These investigators also confirm the high incidence of this disease in men. Although the total number of men in this series was greater than women, the mortality rate of females was higher than in the males, for 45.5 per cent of the females expired as against 31.8 per cent of males. Similar findings were described by Zinn and Cosby.⁶

The average age was 59. The youngest was a 28 year old male and the eldest was an 89 year old man. It has been the impression of the authors that the more rest, nursing care and pleasanter surroundings a coronary patient has, the better are his chances for recovery. A glance at Table 1 shows that this was true in our series.

Fifteen of 25 general service patients expired; 16 of 53 semiprivate patients expired and 11 of 42 private patients died. Thus the mortality rate was 60 per cent in ward cases and only 26.7 per cent in a larger group of private patients. Of course these results cannot entirely be attributed to the factors enumerated above. General service patients are more

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SUMMARY

The authors review a series of patients exhibiting myocardial infarction admitted to St. Vincent's Hospital, Bridgeport over a one year period. A preponderance of this disease was found in males. The overall mortality rate was 34.7 per cent and the average age 59 years. The chief problem of treatment lies in making it early and effective since no deaths occurred after the second week. The use of anticoagulants in the treatment is discussed; also, the complications which arise. The cases are divided into age groups, showing an increase of mortality in the same ratio as age.

TABLE 1
MORTALITY RATE RELATED TO TYPE OF HOSPITAL ACCOMMODATIONS

ACCOMMODATION	TOTAL NO.	DEATHS	PERCENTAGE OF TOTAL
General service	25	15	60
Semiprivate	53	16	30
Private	42	11	26.7
Totals and average mortality	121	42	34.7

apt to be older and to have been battered a bit by the rigors of an impecunious existence, long before developing their myocardial infarctions. It should also be noted that this is a small series and actually very few patients were treated on general service, a trend in keeping with the times. The figures do lend some support, however, to the views of us who still feel that patients with heart disease deserve rest and quiet rather than activity during the acute phase of the illness.

A closer scrutiny of the mortality figures demonstrates the chief problem in the management of myocardial infarction. Sixteen of the 42 deaths, or 38 per cent of the total, occurred during the first day. By the end of the first week 86 per cent of the deaths had already occurred. Not one death appeared after the end of the second week. This illustrates clearly that the chief problem of myocardial infarction lies in treating effectively the severely ill patients, usually in shock and usually with large infarcts, as soon as the illness is diagnosed. It would also appear to us that a mortality curve of this nature minimizes the importance of embolic episodes as a cause of death in this disease. It seems clear that the chief reasons affecting the mortality are the size of the infarct and the collateral circulation available for compensation of the original insult.

Controversy continues over the use of anticoagulant therapy. The anticoagulants used in this series were Heparin initially and Dicoumarol for continued management. A patient to be considered "dicoumarolized" received the drug for at least two weeks and maintained a satisfactory prothrombin level throughout most of this period. Seventy-seven patients were so treated of whom eighteen or 23.1 per cent expired. Forty-four patients did not receive an anticoagulant. Twenty-four or 52 per cent of these expired. A quick glance, therefore, would show the life saving qualities of such therapy. But obviously the sixteen patients dying shortly after admission could not be considered as fully treated. If these are subtracted from the total in the second group, the size of that group is reduced to twenty-eight patients, only eight of whom expired, leaving a gross mortality of 28.4 per cent which compares favorably with the patients who received anticoagulants. This method of analysis we feel should be applied to any paper discussing the merits of dicoumarol therapy. Obviously, inclusion of the early deaths in comparative tables must favor the patients treated with anticoagulants. In reviewing deaths also it should be obvious, because of the high early mortality in this series, that very few could have occurred from pulmonary embolism. In fact, only three instances of such a complication were found in the series, a number too small to permit statistical analysis.

These cases were reviewed for the presence of complications of the original disease. Congestive heart failure was noted at some time in the course of their hospitalization in 54 patients or 47.8 per cent

of total. Thirty-eight were men and 16 were women. Twenty of the men and 16 of the women suffering from this complication expired.

TABLE 2
MORTALITY RATES IN PATIENTS WITH CONGESTIVE
HEART FAILURE

SEX	NO. OF CASES	DEATHS	PERCENTAGE OF TOTAL
Males	38	20	52.5
Females	16	7	43.6
Totals	54	27	50.0

The average mortality for this group of cases was 50 per cent which is higher than for the entire series. Congestive failure is relatively common in myocardial infarction and it deserves more energetic treatment. We do not feel that there is any greater danger to a patient's life in treating congestive failure with digitalis, either in the presence or absence of myocardial infarction.

Diabetes mellitus was noted in 16 patients. As might be anticipated, 13 of these were women. However, the females fared better than the males because the three men died but only four females expired. The mortality rate for this group as a whole was 46 per cent.

An appreciable number of patients developed cardiac arrhythmias or conduction disturbances during their hospital stay. These totaled 26 or 21.4 per cent of the total. The most common of these was bundle branch block which occurred in 11 patients, followed by auricular fibrillation in nine patients. The remaining cases consisted of paroxysmal auricular tachycardia, its ventricular counterpart, and atrioventricular conduction defects. The presence of these abnormal physiological patterns did not appreciably increase the mortality. The overall death rate in this group was 33.4 per cent, roughly the same as that for the entire series. It is quite possible that some of these patients had had arrhythmias prior to their hospital admission. This is particularly applicable to the cases of bundle branch block.

It was possible to localize the infarction of 88 patients. Forty-five had anterior or anterior-lateral infarcts, 10 of whom died for a mortality rate of 22.2 per cent. Forty-three had posterior or posterior-lateral infarcts. Eight of these expired giving a mortality for this group of 16.3 per cent. This fails to conclusively demonstrate the better prognosis of posterior wall infarction.

The patients were broken down into three age groups, namely, 20 to 40; 41 to 60; 61 to 90. There were five patients under the age of 40, none of whom expired. Of 56 patients in the second group, 14 died for a mortality rate of 24 per cent. There were 60 patients over the age of 61; 27 of these died for a mortality rate of 45 per cent. This shows conclusively that the mortality rate of myocardial infarction increases with age. As in most other illnesses, younger patients fare far better than their elders.

TABLE 3
MORTALITY RATE RELATED TO AGE ON ADMISSION

AGE GROUP	TOTAL CASES	DEATHS	MORTALITY PERCENTAGE
20 to 40	5	0	0
41 to 60	56	14	24
61 to 90	60	27	45

This contradicts a belief that the latter had a more adequate collateral coronary circulation and thus survived infarction better than young persons. It is probable that atherosclerosis is less generalized in the young group, affording a better vascular reserve for the myocardium.

DISCUSSION

Most of the findings in this review are in accord with previous papers on the same subject. It confirms the greater frequency of myocardial infarction in men, but the greater mortality of the disease in women unfortunate enough to contract it. Somewhat disturbing is the greatly higher mortality amongst the general service group. Some reasons for this have been already stated. Certainly the general service patients now seen in the wards of community hospitals are different from those of twenty years ago. Today these patients are prone to be very old, a group already suffering from other illnesses, and the unsalvagable derelicts of the community's "skid row." Thus they are in the category of the unemployable. Nevertheless, the authors cannot dismiss the therapeutic virtues of pleasant surroundings, good nursing care, quiet and rest that are most likely to be found in the private pavilions. It is felt that these measures contribute as much to recovery as any of the vasodilator or anticoagulant drugs.

The high incidence of congestive failure in this series, 47.8 per cent of the total, is a compliment we feel to the diagnostic acumen of the physicians treating these patients. From personal experience it is our belief that this complication is common with myocardial infarction, and is frequently overlooked during its early stages. Too many physicians

procrastinate too long before instituting effective measures, namely, digitalis and diuretics. Unfortunately this delay is based upon older writings which continually mention the hazards of digitalis therapy in the presence of myocardial infarction. Untreated congestive heart failure is a greater danger than the proper dosage of foxglove. It was somewhat surprising to find that patients suffering a second or third infarction survived, at least in this period of time, as well as those with a first episode. It is the authors' feeling that this conclusion may possibly be erroneous due to the size of the series. It was not surprising to find younger people surviving better than elder patients. It is most likely that as time goes by and the number of young sufferers from the disease increases (as seems to be happening) these statistics will prove valid.

A look at the mortality according to time after the attack, however, vividly illustrates the great problem which must be overcome if mortality rates are to be appreciably lowered. The greatest number of deaths occur relatively soon after the onset of the acute attack. Many of these patients develop the shock syndrome as a prelude to exitus. This syndrome and this type of mortality curve demonstrates that the size of the infarct and the collateral circulation available for compensation determine the outcome of the disease. Thus, while it is hoped that the use of the newer pressor amines will lower the mortality of myocardial infarction, it should be remembered that essentially this is symptomatic therapy. The shock is secondary to the severe infarction. For this reason also, anticoagulant therapy can prove of some but really limited value, as it reaches its effectiveness after the greatest danger has passed. The therapy to be sought for are those measures which will most effectively prevent or else treat the infarct per se, since the physician has in his armamentarium many procedures to manage the complications.

We wish to acknowledge the assistance rendered to us by the St. Vincent's Hospital medical librarians: Sister Mary Victor and Miss Marilyn Wright.

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THE PHYSICIAN'S PLACE IN THE HEALTH PROGRAM

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SUMMARY

Whether in an official department of public health, in other governmental or institutional work, or in private practice, the physician is a key person in community or personal health. The author outlined his thoughts on this subject at the request of the editor of the *Journal of the Health Education Association of the Philippines*, where they appeared in Vol. 1, No. 4, 1954. These ideas, which represent only personal views, will be of interest to other Connecticut physicians, and are reprinted with the permission of the *Journal*.

The author visited the Philippines in 1921, 1926, and with UNRRA in 1945, and later arranged the programs in the United States of 100 Filipinos under the Philippine Rehabilitation Act.

disease, tuberculosis, leprosy, laboratory, industrial health, biostatistics, mental health, and chronic diseases are examples of fields frequently calling for a physician. One may head a division or may work in a clinic; usually a division chief has come up through clinical experience. Such work in a clinic gives the doctor a sense of service to individuals, together with a feeling that he is helping deal with a community problem. The physician is of course associated with other workers, but this clinical work only he can do.

In many places, as in the Philippines, the Department of Health is responsible for the operation of various governmental hospitals, general or special. These call for physicians for various kinds of work, administrative or clinical, the latter including general practitioners and specialists. Hospitals sometimes are interested in their patients only from the time of

IN the opinion of the public, the physician is a key person in public and private health. People expect him to lead them. They turn to him for guidance in matters of health, large and small. This is true no matter what kind of medical work he does. His position is thus one of responsibility and broad opportunity. Having learned from my visits and my friendships how much the Philippines and the United States are alike in social patterns, I venture to suggest here the many different roles physicians can play in the health program in either country.

It is usually expected in the world today that the post of health officer will be filled by a physician. This is due to more than a vague feeling that the doctor knows about disease and health. Practically, a physician's training has given him background in such important matters as bacteriology, parasitology, epidemiology—the spread, diagnosis and control of communicable diseases, still enormously important in most of the world, obstetrics and pediatrics dealing with health of mothers and babies, two susceptible groups, surgery and chronic diseases which fill so many hospital beds, and mental illnesses which are of growing importance today. He knows something of a hundred diseases, how to recognize them, and what to do about them. Some knowledge of prevention has long been part of his training. Now he is being taught still more about prevention and about thinking of the entire community as a patient whose symptoms and progress can be studied from statistics. His training and experience help him to understand and work cooperatively with the nurse and the engineer, the laboratory worker, the dentist, and others. He has a wide experience with human beings, although he did not study administration itself at medical school. As a result of all this, today the physician is preferred as health officer in both large and small departments.

In a larger health organization, physicians are needed for posts other than that of health officer. Maternal and child health, epidemiology, venereal

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entrance to the day of discharge. Such a hospital is serving its public only in part. It has an opportunity and a need for active cooperation with the rest of the Department of Health and the community through the outpatient department, the public health nurse, and the medical social worker. The physician in the hospital and his brother at the health office need to work together much more closely than is sometimes the case.

Outside of the Department of Health itself there are other kinds of closely related medical work. The school physician may serve under a board of education. If he lifts his eyes above routine physical examinations he has a great opportunity. The Army, Navy, and Air Force need medical officers for central administration, for field public health work at the posts, and in clinics and hospitals. An industrial plant may need a physician, to be responsible not only for medical care in a clinic, but also for conditions within the plant or for a system of home care for workers and their families. The Department of Welfare must have part- or full-time medical service for its institutions. Occasionally a physician is employed by a private organization, such as the Infantile Paralysis Foundation or the Red Cross.

The part the private practitioner plays in public health must not be overlooked. Many physicians are engaged in the private practice of medicine. Some do part-time work in a Health Department clinic, but many do not. Some of these latter feel they are concerned only with sick people in their homes and therefore have nothing to do with the Department of Health. On the contrary, relations should be close and cordial. To the Department the practitioner is expected to report births and deaths, communicable and industrial diseases, cancer, and other conditions of concern to the community. In turn, he may refer his patients to diagnostic clinics of the Department, send specimens to its laboratory, or call on its specialists in consultation. He may be asked to serve on a health committee, a board of health, or a school board, where he will deal with health matters. To his patients he is properly a guide and adviser, helping them to avoid disease and develop the best health possible.

Both he and the Department advise the community, but the practitioner's advice is tailored to the needs of the individual patient. Any criticism of the Health Department should be constructive.

People turn to all physicians, private and public, for guidance in health matters; if the leaders appear to fall out the people are confused. In turn, the health officer should consider the private practitioner as an essential ally in reaching the individuals making up the community which they both serve.

Research is an essential part of a health program. One of the discoveries we make in growing up is that there are still many things to be found out. Research may be carried on in a laboratory, as when chemicals are tested on their ability to kill the snails that carry schistosomiasis. The results of these tests must be confirmed under field conditions, in the ditches or streams where the snails live. Research is also done in hospitals, on the changes as a disease progresses or on ways of treatment. The great new Clinical Center of the Public Health Service in Washington is an example of the way in which physicians, chemists, nurses, dentists, engineers, and many other groups are working together in research.

The physicians teaching in a medical school also make a contribution to public health. Their pupils will be the health workers, public and private, of the future, and on the quality of the graduates will largely depend the quality of their service to community health. In addition, the stress laid by the faculty on the prevention, partial or complete, of diseases studied will influence the thinking and practice of the physicians who come from that school. Each school should have a department of preventive and social or community medicine, to develop student thinking along community lines, but the idea of prevention itself should spread to instruction in all departments. Both the medical school and the department of health should be interested, too, in post-graduate education for physicians and other health workers, for to be effective we must keep learning all our lives.

This is a broad picture of the contribution which every physician, in whatever kind of practice, may make to the health of his community. He does not work alone. Many other groups share in the opportunity and the work. Yet each physician is singularly a part of the health assets of his community and should so consider himself. Any health program must consciously or unconsciously include him as a substantial part. He should expect to be included, and to play that part.

CONNECTICUT STATE MEDICAL SOCIETY

163rd ANNUAL MEETING

STRATFORD HIGH SCHOOL, STRATFORD

April 26, 27, 28, 1955

PROGRAM

Tuesday, April 26

MUSIC ROOM

ANNUAL MEETING OF THE HOUSE OF DELEGATES

COLE B. GIBSON, *Speaker of the House, presiding*

- 10:00 CALL TO ORDER
BUSINESS SESSION
- 1:00 LUNCHEON FOR OFFICERS, MEMBERS OF THE HOUSE, AND GUESTS
-
- 2:00 RESUMPTION OF BUSINESS
- 7:00 ANNUAL DINNER OF THE COUNCIL
-

Wednesday, April 27

- 9:00 REGISTRATION—Exhibit Hall
- AUDITORIUM
- 9:00 MOTION PICTURE FILM
- 9:30 CALL TO ORDER—President of the Society
ADDRESS OF WELCOME—President of the Fairfield County Medical Association
- 10:00 PRACTICAL PROBLEMS AND CLINICAL ERRORS IN THE CARE OF THE AGED
Frederick D. Zeman, *New York*

Wednesday, April 27 (Continued)

- 10:35 NON-SPECIFICITY OF THE ELECTRO-CARDIOGRAM IN CORONARY ARTERY DISEASE
Harold D. Levine, *Boston, Massachusetts*
- 11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS
- 11:40 VISUALIZATION OF THE NON-FILLING GALLBLADDER OR THE BILIARY TREE AFTER CHOLECYSTECTOMY, WITH A NEW I.V. CONTRAST MEDIUM (CHOLAGRAFIN)
Herbert M. Stauffer, *Philadelphia, Pennsylvania*
- 12:15 THE DEPRESSED OFFICE PATIENT
Paul Hoch, *New York*
- 1:00 LUNCHEON—Cafeteria of the High School
VISIT TO TECHNICAL EXHIBITS
-
- 2:00 Program Arranged by Connecticut Academy of General Practice
-

Wednesday, April 27

MUSIC ROOM

- 9:15 FILM—Presented by Beckett M. Howorth, Stamford
- 10:00 CONGENITAL ANOMALIES—CAUSE AND PREVENTION
Theodore H. Ingalls, *Boston, Massachusetts*
- 10:35 FAMILIAL INFECTIONS
William S. Jordan, *Cleveland, Ohio*
- 11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS
- 11:40 HORMONES IN MANAGEMENT OF RHEUMATIC FEVER
Gene H. Stollerman, *Irvington-on-Hudson, New York*
- 12:15 ALLERGIES IN CHILDREN
Douglas E. Johnstone, *Rochester, New York*
- 1:00 LUNCHEON—Cafeteria of the High School
VISIT TO TECHNICAL EXHIBITS

PROGRAM

Thursday, April 28

9:00 REGISTRATION—Exhibit Hall

AUDITORIUM

9:15 MOTION PICTURE FILM

10:00 WHEN SHOULD AN OVARECTOMY BE DONE?
Clyde L. Randall, *Buffalo, New York*10:35 CHRONIC URINARY BLADDER IRRITATION AND DISABILITY
Clarence G. Bandler, *New York*

11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS

11:40 ROLE OF ANESTHESIA IN SURGICAL MORTALITY
Henry K. Beecher, *Boston, Massachusetts*12:15 RADICAL ABDOMINAL AND PELVIC SURGERY
Langdon Parsons, *Boston, Massachusetts*1:00 LUNCHEON—Cafeteria of the High School
VISIT TO TECHNICAL EXHIBITS

2:00 Program Arranged by The Connecticut Society of American Board of Surgeons

Thursday, April 28

MUSIC ROOM

10:00 THE TREATMENT OF THE PAINFUL SHOULDER
Paul C. Colonna, *Philadelphia, Pennsylvania*10:35 INDICATIONS FOR SPLENECTOMY
Claude-Starr Wright, *Columbus, Ohio*

11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS

11:40 THE MEDICAL EXAMINER
LeMoyne Snyder, *Lansing, Michigan*12:15 ACUTE HEAD INJURIES
Elisha S. Gurdjian, *Detroit, Michigan*1:00 LUNCHEON—Cafeteria of the High School
VISIT TO TECHNICAL EXHIBITS

Wednesday, April 27 — Thursday, April 28

3:30 SECTION MEETINGS

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

Antibiotics and Viral Diseases

While immense therapeutic progress has followed the development of the sulfa drugs and antibiotics such as penicillin and others of this class, there is still one group of etiological agents, namely, the viruses, which has in the main proved resistant to all of the newer remedies. It is true that a few viral diseases, such as the psittacosis and venereal lymphogranuloma, are due to etiological agents which, in many cases, can be destroyed by Aureomycin and chloramphenicol. This is probably due to the fact that the particular viruses which cause them are more closely allied to rickettsiae than other viruses, those causing influenza, for example.

This failure of antibiotics to destroy most viruses does not mean, however, that they are useless in the treatment of viral infections. It is true of many viral infections that their mortality is due, not to the original infection, but to the secondary bacterial complications, particularly the pulmonary ones. As Smadel* points out, this was strikingly illustrated by the severe influenza epidemic of 1950 in the Canadian Arctic. Whereas before a medical team was flown in 16 deaths had occurred among 90 patients, the treatment of patients with penicillin, after the arrival of the team, led to an abrupt cessation of fatalities.

There is some evidence that certain local viral infections, notably trachoma and inclusion blennorrhea, which have certain points in common with the psittacosis-lymphoma venereum group, may be

favorably influenced by Aureomycin and chloramphenicol sometimes, as in the eye infections, applied locally and sometimes administered to produce a systemic effect. But when we consider that there are over twenty recognized viral infections these results constitute only a small start on a large problem. It is to be hoped that in the not far distant future some drugs more generally destructive to viruses may be discovered.

G. B.

National Security and the Scientist

Now that much of the smoke created by the Senator from Wisconsin has cleared away it is a fitting time to review our nation's security-screening program, particularly as it affects the scientist and his research. The Board of Directors of the American Association for the Advancement of Science has recently* indicated four points which it considers basic to the security program. These are: (1) a security-screening program is made necessary by the peril of the times; (2) examinations of the character of persons likely to be entrusted with vital information must go beyond a determination of loyalty; (3) the security program is for the protection of the whole community; (4) security-screening programs are a means to an end rather than an end in themselves.

Military strength today depends to a large extent upon science and we as a nation are just beginning to realize that scientific knowledge cannot be kept

*Smadel, Joseph E.: Bull. N. Y. Acad. of Med., 1951, 27:221.

*Science, 120:3128, December 10, 1954

secret by the same security practices that serve to safeguard military information. So-called scientific secrets are soon nonexistent for in a relatively short time such secrets are discovered by scientists of other nations. In fact, there are several instances on record where the discovery has been made in one or more countries simultaneously.

It has been repeatedly pointed out that our security as a nation depends on maintaining the most favorable environment for the advancement of science, one in which our scientists will be free to use their abilities to the utmost.

The time has arrived for some positive thinking on this problem. We should be asking "How can we best aid national progress?" instead of "How can we avoid the danger of leaks?" Or "How can we maximize our gains?" instead of "How can we minimize our losses?" Too often when a scientist is selected for a position (except one where necessarily closely guarded information is involved) the individual's ability to make a positive contribution to the nation's welfare and progress is overlooked and instead only the security risk is considered.

The American Association for the Advancement of Science is proposing two changes: (1) That greater weight be given to a man's potential contributions. Beware of the risk but consider the gain and if the gain is greater than the risk we can afford to accept it. The whole man should be evaluated; his strength and possible contributions as well as his weaknesses and possible danger. (2) That the risk be measured with more regard for the nature of the work to be done than has frequently been true in the past. Disloyalty has been confused in these days of Senate committee investigations with security risk. "Disloyalty," to quote the Association, "is not to be tolerated anywhere, but stringent security precautions are appropriate only when the information to be guarded justifies the secrecy."

Basic research has suffered in recent years from the castigations and insinuations aimed at many of its talented investigators. We need a positive program of security. The only question is, are we bold enough and do we believe enough in the fundamental loyalty of American scientists and in their ability to keep our nation in the forefront? Only as original scientific research can carry on its work unhampered will we as a people progress. This applies equally to medical research upon which our outstanding progress in the past half century has depended.

Light In The Fog

Members of the Society have been confused for more than two years concerning the purchase of professional liability insurance. Agents have been uncertain of information they have given and the "tie-in" sales have been annoying.

Finally after many efforts we have been able to obtain a statement of policy from the Aetna Casualty and Surety Company, the insurers that carried the Society's group contract for many years until it was terminated about two years ago and that continues to write professional liability coverage for most Connecticut physicians. The statement reads as follows:

"Perhaps it would be well to first of all bring to the attention of the members the findings of the officials of one medical society as respects the difficulties encountered in the field of professional (malpractice) coverage:

"It is a known fact in casualty insurance that more companies have been in and out of the malpractice insurance business than has been the case of any other form of liability insurance. It is a difficult form of insurance to write and, so far as we know, it has never proved satisfactory to any company. The inordinate lag in the reporting and disposing of actions against doctors, has made the loss experience look favorable during the early years of writing. Later when the companies learn the actual cost of the business, there is a rude awakening. When that occurs, the companies are forced to seek greatly increased rates or withdrawal from the business, usually the latter. It is not unknown in the past when companies have withdrawn from the field, that many doctors, most of whom have never had a claim, suddenly find themselves unable to purchase insurance except at what they feel were exorbitant rates. Because of the unsatisfactory nature of this business, as near as we can ascertain, it is being written by a very limited number of companies.'

"The Aetna has been engaged in writing this class of business some 40 years, and today is one of the largest writers.

"We appreciate the fact that professional coverage is vitally essential to the ethical practitioner of medicine and surgery. Since this coverage has been highly unprofitable, we came to the conclusion that, rather than stop writing it, we would establish the following underwriting program which we hope will enable us to carry on.

"(1) Professional liability coverage for the ethical practitioner will be handled only when the risk comes to us through a regularly licensed agent of our Company. We believe this requirement is reasonable since we do not feel we should be expected to accommodate brokers who offer us only this line of business. It seems only logical that such brokers should place their doctor client's professional liability insurance with the same carrier to which he gives the doctor's other more favorable lines of insurance.

"(2) As to physicians and surgeons now insured with us through licensed Aetna agents, we are willing to renew their professional liability coverage regardless of whether or not they carry any other lines of insurance with us at this time. It is, of course, only natural that our agent in his desire to be of service in rounding out his client's insurance needs, will be asking his doctor client if he has other protection he might now write or obtain the promise of writing on expiration date.

"(3) As respects doctors not presently insured with us, we are willing to provide professional liability protection through an Aetna agent in such cases where our agent is also favored with a reasonable portion of the doctor's more desirable lines or will be promised such lines upon expiration.

"There is considerable doubt that the increased rates which have recently been established country-wide will improve the over all situation sufficiently to make this an attractive and profitable line of business. It can readily be understood it is only when any particular class of risk shows a satisfactory underwriting profit that a carrier is encouraged to intensify its production and volume of such business, and vice versa, establish a more conservative program during the period of adverse experience."

Lord Beveridge — 1954

Whatever one may think of Lord Beveridge it is safe to say that he is one of the significant men of our times by reason of the fact that he developed and saw adopted his so called "Cradle to Grave" Health Insurance Act which has been in effect in Britain since 1948. Students of Society, especially that portion which concerns health, will be interested in an address he delivered before the Annual Conference of the British Contributory Schemes Association (1948) in Bristol on November 5, 1954, reported in the *British Medical Journal* for December 11, 1954.

He spoke on "The Role of the Individual in the Health Service."

Most of us had supposed that the Hospital Contributory Schemes, which faintly resemble our own Blue Cross, had been doomed to extinction by the Health Act. We are surprised to learn that they are flourishing in England where they supplement hospitalization expenses in one way or another for one-fourth of the population, though they have never developed in Scotland. Lord Beveridge praises these organizations and hopes that they will survive the pressure of the Labour Party to abolish completely all "pay beds." It is repugnant to Labour to see anyone, by paying extra, able to "jump the queue." Lord Beveridge would abolish the need for queues by furnishing ample facilities, but he observes that liberty and variety are more important than equality.

The solid basis of the Contributory Schemes he sees as the organization of self help, augmenting compulsory State Insurance. He sees also emerging another role as that of organizing charitable action for helping others. He states that £400,000 have been allocated by the Schemes for charitable purposes in the last six years.

Leagues of Hospital Friends, fostered by the Schemes, are arising independently to organize voluntary workers. These, he believes, will find in the next generation their scope in personal services rather than in the contribution of money.

Lord Beveridge mentions three phases of the social revolution which bear on this situation.

(1) The Family. In 1901 for every person of pension age there were ten of working age and five children under 15 years. Today for every oldster there are only five workers and one and one-half children. In 20 years there will be only three workers and there will be more pensioners than children. "There will be a new call for service by neighbors."

(2) Income. There are no longer many persons of large income who make substantial charitable contributions. We must somehow democratize charity as well as government. (It is interesting and perhaps significant that he uses the word democratize and not socialize.)

(3) Leisure. There are no longer large numbers of wealthy persons with leisure which made possible much charitable work. The almost complete disappearance of the servant class and the shifting of leisure to the many has left a serious want, and he said "if Britain is not to lose the saving spirit of

voluntary action we have somehow to democratize personal service as well as charitable spending and government."

Lord Beveridge sees the need for each hospital to have its own League of Hospital Friends whose key word of policy should be supplementation. He is himself president of the National League of Hospital Friends. He describes the wide variety of things and services which may be provided.

The role of voluntary action will depend largely on the nature of the Health Service proper. A comprehensive report on the Service will be made during the coming year by the Guillebaud committee. As stated above he hopes that the pay bed will be continued. He still believes firmly in the "Health Center," which he wrote into the Health Insurance Act. In spite of the fact that this facility was planned along lines suggested by the special committee of the British Medical Association, and although it is a statutory duty of the local authorities to establish them, there are at this time only ten Centers in operation. He says it is reported that there is a fundamental reluctance on the part of the medical profession to their establishment.

The Health Service is divided into three parts, administered by unconnected authorities, the general practitioners, the hospital and specialist services, and the local authorities, health and welfare to us. Lord Beveridge hopes that the Guillebaud committee will suggest a way to coordinate these services and he points to the Bristol Health Center as a successful demonstration of its advantages.

Lord Beveridge suggests that The Leagues of Hospital Friends might help not only in matters outside the Health Service, but might even assist in the work of the Service itself. This appears to one on this side of the Atlantic as an odd suggestion, perhaps a bit utopian. We must remember however that we have long had voluntary women's organizations working in the Veteran's Administration Hospitals and women's auxiliaries are found in some of our municipal hospitals.

As for the National Health Service, it is not surprising that Lord Beveridge sees it as "a beneficent revolution in our social institutions, a revolution on which there can be no going back. But it leaves plenty for the individual to do." His role is supplementation and the Hospital Contributory Schemes Association is the normal organizer of supplementation. These Schemes "are an outstanding example of

voluntary action refusing to be put out of action by a Welfare State." He asks why these schemes, which in six years have covered one-fourth of the population of England, should not cover four-fourths, and why not Scotland for that matter.

Much can be learned from the experience of our British cousins. Not all their remedies would agree with us but we cannot disregard such an accumulation of social experience. It has appeared that there is in the evolution of the Health Service a resemblance to the so-called Poor Man's pudding, made of bread and milk and very little else, which is now being made more palatable and perhaps more nutritious by adding raisins, nutmeg and other good things. It is significant that Lord Beveridge, its chief cook, is suggesting this supplementation.

In a speech before Rotary International last November, Lord Beveridge explained why he preferred to speak of "Welfare Society" instead of "Welfare State." He sounded as if he had taken to heart the sayings of those individualists, Herbert Spencer and Abraham Lincoln. "Welfare was right" said he, "but State gave to some people the idea that for everything they desire in welfare men should look to the State and use their votes to get those services. Some things, I agreed, must be done by the State, because they would not be done otherwise, but many more things would be done best by private citizens. Welfare requires free cooperation of the State and the individual thinking and acting both for himself and for his neighbors."

Are You Interested in Trauma?

If you are a physician practising in the State of Connecticut and have occasion to treat any patients suffering from trauma you are invited to affiliate yourself with other physicians on the Connecticut Committee on Trauma of the American College of Surgeons. The College first established its Committee on Fractures in 1922. Seventeen years later this committee joined forces with the Committee on Industrial Medicine and Traumatic Surgery and called itself the Committee on Fractures and Other Trauma. In 1950 the name was changed to the Committee on Trauma.

In order to carry out the objectives of the College's Committee on Trauma, organization has further been developed by the formation of twelve Regional Committees, each of which is further broken down into State Committees. The State

Committee chairman is expected to help establish and organize local Regional Committees within his State, either comprising several cities and towns or established in a single community.

The Committee on Trauma of the American College of Surgeons has established as its objectives (1) the development and improvement of the teaching of trauma in the United States and Canada, and (2) the improvement of the transportation and care of the injured person. On the local Regional Committees will be found orthopedic surgeons, general surgeons, neurosurgeons, plastic surgeons and, as in the case of one such local committee in Connecticut, an occasional gynecologist. Membership on these local committees is not limited to members of the College, although Fellowship in the College is desirable.

In Connecticut there are at present local Regional Committees in Bridgeport, Bristol, Derby, Greenwich, Hartford, Manchester, Meriden, Middletown, New Britain, New London, New Haven, Norwich, Southington, South Norwalk, Stafford Springs, Stamford, Torrington, Waterbury, Willimantic and Winsted. The Connecticut Committee on Trauma believes that it has only begun to scratch the surface, that the treatment of trauma can be improved in this State, and that more physicians treating such cases should interest themselves in this phase of the American College of Surgeons' program. Scientific meetings for the discussion of trauma subjects should be more frequent, there should be an increased effort to teach the principles of trauma in our hospitals and possibly in our medical schools, and local lay organizations such as civil defense, police and fire should be exposed to more opportunities for instruction in this field by interested surgeons. Improvement in the field of rehabilitation of the trauma patient both in hospitals and afterwards should be sought. In fact, there are so many ways in which the Connecticut Committee on Trauma can increase its worth to the community that the interest of every physician who ever cares for a victim of trauma should be aroused and his active support given to this worthwhile field of endeavor.

A "Dog Tag" in Pregnancy

Richard Torpin, M.D. of the Medical College of Georgia, writing in a recent issue of the *Journal of The Medical Association of Georgia*, offers a proposal which we have long felt was needed, viz., a

"dog tag" for pregnant women. Dr. Torpin lists the factors making such a "dog tag" of value and suggests that on one side appear the expected date of delivery, the result of the blood test for syphilis, blood group, Rh factor and hemoglobin, A. P., transverse and interspinous measurements of the pelvis, any chronic disease or allergy known to exist, and the presentation of the fetus. On the opposite side would appear the woman's name, age, para and gravida numbers.

Whether or not all the information listed above is necessary, at least the blood data and disease information is very important. One might add to the list previous transfusions. It is recognized by skilled obstetricians today that information concerning the Rh factor and blood group is of great importance. Emergencies often arise and securing of this important information may be unnecessarily delayed.

Why not a "dog tag" for every pregnant woman in Connecticut? The question seems to be "who will furnish it?" The State Department of Health is required by law to process blood tests for syphilis but the determination of the Rh factor and the blood group determinations are done by the obstetrician because the State budget cannot bear the expense of these procedures. Other medical centers supply at least a blood group and Rh factor card.

At the present time it seems that the way must be blazed by the private obstetrician if the "dog tag" system is to be initiated. It will afford another opportunity for Connecticut to exercise leadership in the field of medicine.

New Officers of Connecticut Health League Elected at Annual Meeting

Dr. Ira Dow Beebe, Bridgeport dentist, was elected president of the Connecticut Health League at the annual meeting of organization, January 12, in New Haven. He succeeds Dr. Charles C. Wilson, New Haven, president of the League during the past two years.

Dr. Alfred L. Burgdorf, Hartford, and Professor Walter McKain, Storrs, were elected vice-presidents and Horace A. Brown, Hartford, was re-elected secretary-treasurer.

Named to the Board of Directors for three year terms were Dr. George B. Darling, New Haven; Dr. Elizabeth Adams, Guilford; and Professor Ruby Jo Reeves Kennedy, New London.

THE PRESIDENT'S PAGE

TO JUDGE A MAN

This month the President's Page is written largely by an illustrious friend; one to whom the term "ghost writer" might be applied far more accurately than to most who have been so designated. Many in our Society can claim his friendship with greater right than I, and the following passages will not be unfamiliar to them. It is my hope that a few may encounter them here for the first time.

"There is nothing I so hardly beleve to be in man as constancie, and nothing so easie to be found in him as inconstancy. View all antiquity over and you shall finde it a hard matter to chuse out a dozen of men that have directed their life unto one certaine, settled and assured course, which is the surest drift of wisdom . . . Our ordinary manner is to follow the inclination of our appetite, this way and that way; on the left and on the right hand; upward and downe-ward, according as the winde of occasions doth transport us. We never thinke on what we would have, but at the instant we would have it; and change as that beast that takes the colour of the place wherein it is laid. What we even now purposed we alter by and by, and presently returne to our former biase; all is but changing, motion, and inconstancy. We goe not, but we are carried; as things that flote, now gliding gently, now hulling violently, according as the water is either stormy or calme. Every day new toyes, each houre new fantasies, and our humours move and fleet with the fleetings and movings of time. We flote and waver between divers opinions; we will nothing freely, nothing absolutely, nothing constantly."

"He whom you saw yesterday so boldly-venturous, wonder not if you see him a dastardly meacocke (poltroon) tomorrow next; for either anger or necessitie, company or wine, a sudden fury or the clang of a trumpet, might rowze-up his heart and stir up his courage . . . And whosoever shall heedfully survey and consider himselfe, shall finde this volubility and discordance to be in himselfe, yea, and in his very judgement. I have nothing to say entirely, simply, and with soliditie of my selfe, without confusion, disorder, blending, mingling. . . Therefore, to judge a man, we must a long time follow and very curiously marke his steps; whether constancie doe wholly subsist and continue upon her owne foundation in him. (He) who hath forecast and considered the way of life, whether the variety of occurrences make him change his pace, let him run on; such a one goeth before the wind."

"No man makes any certaine designe of his life, and we deliberate of it but by parcels. A skilfull archer ought first to know the marke he aimeth at, and then apply his hand, his bow, his string, his arrow and his motion accordingly. Our counsels goe a stray, because they are not rightly addressed, and have no fixed end. No winde makes for him that hath no intended port to saile unto . . . We are all framed of flaps and patches, and of so shapelesse and diverse a contexture that every peece and every moment playeth his part. And there is as much difference found betweene us and ourselves, as there is betweene ourselves and other(s)."

"It is no part of a well-grounded judgement, simply to judge ourselves by our exteriour actions: A man must thorowly sound himself, and dive into his heart, and there see by what wards or springs the motions stirre. But forasmuch as it is a hazardous and high enterprise, I would not have so many to meddle with it as doe."

It is deeply gratifying that the past half century has brought greater understanding of man's spirit, of the "inner springs" from which flow the powerful influences that color and shape his life. We think of the exploration of this inner self for therapeutic purposes as essentially a modern achievement, but the words quoted above indicate that its power, complexity, and apparent inconsistencies were recognized long ago by a contemplative, wise, and deeply perceptive observer. Is it too fanciful to find in the closing words a warning that those who delve into man's unconscious shall be carefully trained for this "hazardous and high enterprise"?

The name of our guest-author is Michel de Montaigne, who published these and other impressive observations in 1580.

H. M. Marvin, M.D.

The excerpts above are all from the first chapter of Book 2 of Montaigne's Essays as translated by John Florio. They are given in proper sequence and without alteration except the addition of the matter in parentheses and the deletion of several commas. The source is the sumptuous edition designed by Bruce Rogers and published by the Riverside Press in 1902.

The image features a background of concentric, overlapping circles in shades of dark grey and light grey, creating a tunnel-like effect. The circles are slightly offset from each other, giving a sense of depth. In the lower right quadrant, the letters 'ACH' are prominently displayed in a bold, orange, sans-serif font. The letters have a slight 3D appearance with a dark outline.

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THE CHARTER AND BY-LAWS

The Connecticut State Medical Society was incorporated and chartered by the Connecticut General Assembly in 1792. This is believed to be the earliest private charter granted by the State of Connecticut. The Society has no constitution, the articles of incorporation serve that purpose and cannot be amended without legislative action. The By-laws implement the Charter and it is under them that affairs of the Society are carried on. The By-Laws can be amended at any meeting of the House of Delegates after proper notice and they are often revised to keep pace with the progress and changing responsibilities of the Society. The By-laws now published include all amendments to date. The first meeting of the Society was held in Middletown on October 9, 1792.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. The charter of The Connecticut Medical Society, approved June 5, 1834, is amended to read as follows: All persons who are, at the time of the passage of this act, members of The Connecticut Medical Society and all physicians and surgeons who shall hereafter be associated with them in pursuance of the provisions of this act shall be and remain a body politic and corporate by the name of The Connecticut State Medical Society; and by that name they and their successors shall and may have perpetual succession; shall be capable of suing and being sued, pleading and being impleaded, in all suits of whatever name and nature; may have a common seal and may alter the same at pleasure and may also purchase, receive, hold and convey any estate, real and personal.

Section 2. The superintendence and management of the corporation shall be vested in a board to be known as "The House of Delegates of The Connecticut State Medical Society," which board shall have power to establish officers in said corporation and prescribe the duties of the several officers and of the members of said corporation and may fix their compensation; to establish the conditions of admission to and dismissal and expulsion from said society; to lay a tax, from time to time, upon the members and to collect the same; to hold and dispose of all monies and other property belonging to the corporation in such manner as it may deem advisable to promote the objects and interests of the society and in general to make such by-laws and regulations for the due government of the society, not repugnant to the statutes of the United States or of this state, as may be deemed necessary.

Section 3. The House of Delegates of the Connecticut State Medical Society shall be composed of, (1) the President, the President-Elect, Treasurer and Secretary of the Society, (2) delegates to be elected annually as hereinafter

provided, by the several county medical associations in this State which heretofore have been and are affiliated with the Connecticut State Medical Society and (3) the members of the Council of the Society.

Section 4. An annual meeting of the corporation, for the election of officers and such other business as may, from time to time, arise, shall be held upon such day in each year as The House of Delegates shall, from time to time, prescribe. Notice of such annual meeting date shall be sent to every affiliated county medical association at least sixty days before each annual meeting date so prescribed.

Section 5. At a meeting to be held at least twenty days in advance of the annual meeting of the corporation in each year, every affiliated county association shall elect a delegate or delegates to represent it in The House of Delegates of this society in the proportion of one delegate to each thirty-five members, or any part of that number, and the secretary of such affiliated county association shall send a list of such delegates to the secretary of this corporation at least twenty days before the date of such annual meeting.

Section 6. There shall be in The House of Delegates, one Councilor from each affiliated county medical association. The Councilors holding office at the time of the passage of this act shall serve out the terms of office for which they were elected. At their annual meeting to be held in 1931, the affiliated county medical associations for the counties of Hartford, New London, Windham, and Middlesex shall each elect one Councilor who shall serve for two years, and at their annual meeting in 1932 the affiliated county medical associations for New Haven, Fairfield, Litchfield, and Tolland counties shall each elect one Councilor, who shall serve for two years. Thereafter each county, in groups as above mentioned, shall, biennially, elect a Councilor to fill said office for a term of two years. Any vacancy in said office may be filled by the county association of the

county in which the vacancy occurs, by election to fill the unexpired portion of the term.

Section 7. The secretary of each affiliated county medical association in this state, shall, within ten days following any meeting of such association at which new members are elected, file with the secretary of the society a list of all members of such association who are at the time in good and regular standing and thereupon all such persons shall become members of The Connecticut State Medical Society without further action.

BY-LAWS

ARTICLE I

NAME

Section 1. Name

Par. 1. The name of this organization shall be The Connecticut State Medical Society.

ARTICLE II

PURPOSES

Section 1. Purposes

Par. 1. The purposes of this Society shall be to federate and bring into one organization the medical profession of the State of Connecticut; to unite with similar societies in other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standards of medical education; and to promote friendly intercourse among the physicians; to enlighten and direct public opinion so that the profession shall become increasingly useful to the public in the prevention and care of disease and in prolonging and adding comfort to life.

Par. 2. The Society is not organized, and shall never be maintained and conducted for the pecuniary profit of its members, officers, or employees but shall be, and remain, a strictly scientific and educational corporation, and no member, officer or employee of the Society shall at any time receive or be entitled to receive any pecuniary profit from the operation of the Society except a reasonable compensation for services actually rendered.

ARTICLE III

ETHICS

Section 1. Ethics

Par. 1. The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

ARTICLE IV

COMPONENT ASSOCIATIONS

Section 1. Component Associations

Par. 1. The county medical associations in the following counties shall be the component associations of The Connecticut State Medical Society: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, Windham.

ARTICLE V

MEMBERSHIP

Section 1. Membership

Par. 1. The Society shall consist of members, student members, associate members and honorary members.

Section 2. Members

Par. 1. All members in good standing in the component associations shall be members of this Society. Physicians whose names are on the official roster of membership of a component association shall be considered in good standing.

Section 3. Student Members

Par. 1. Any person whose legal or family residence is in the State of Connecticut who is a regularly enrolled student and a candidate for the degree of Doctor of Medicine in an acceptable medical school, as provided in Section 1662c of the General Statutes of Connecticut, or any person who is a student in an acceptable medical school located in the State of Connecticut may become a Student Member of the Society. Also, physicians not licensed to practice medicine in Connecticut who are serving as interns or residents in hospitals in Connecticut, for the purpose of extending their education and not primarily for remuneration, may become Student Members of this Society.

Par. 2. Such membership shall be obtained by applying to the Council of the Society on a form provided for that purpose and election by vote of a majority of the Council.

Par. 3. Student Members shall enjoy all of the rights and privileges of membership in the Society except that they shall not be eligible to vote or hold office, and Student Members shall pay no dues.

Par. 4. When such a Student Member is licensed to practice medicine in the State of Connecticut and settles in this State in practice or remunerative employment he shall be eligible at once for election to active membership in the County Association in the County in which he has settled without the waiting period of residence within the County, subject to such regulations as may be imposed by such County Associations.

Section 4. Associate Members

Par. 1. Physicians and others interested in the science of medicine and public health who are not licensed to practice medicine in the State of Connecticut, may be elected as Associate Members in this Society by majority vote of the House of Delegates at any regular or special meeting. Candidates for Associate Membership shall be required to file with the Council a formal application for membership which shall be passed upon by the Council with recommendation to the House of Delegates. Associate Members shall enjoy all of the rights and privileges of the Society except that they may not vote or hold elective office; they may be appointed to serve upon committees and present papers before the Society or any of its sections.

Section 5. Honorary Members

Par. 1. Eminent physicians may be elected Honorary Members by majority vote of the House of Delegates in accordance with Article X, Section 3, Paragraph 4. They shall be accorded the privilege of participating in scientific work.

ARTICLE VI

OFFICERS

Section 1. Officers

Par. 1. The officers of this Society shall be a President, a President-Elect, a First Vice-President, a Second Vice-President, an Executive Secretary, a Treasurer, the Man-

aging Editor of the JOURNAL, a Speaker of the House of Delegates, a Vice-Speaker of the House of Delegates, the elected delegates to the American Medical Association, and a Councilor and Alternate Councilor elected from each component association.

Par. 2. The officers, except the President and the Councilors and Alternate Councilors, shall be nominated by the Nominating Committee and elected annually by ballot by the House of Delegates.

Par. 3. The President-Elect shall be elected annually. He shall serve as President-Elect until the annual session of the Society next ensuing after his election and shall become President upon his installation in the course of that session, serving thereafter as President until the next following annual session and the installation of his successor.

Par. 4. A Councilor and Alternate Councilor who shall serve for two years shall be elected at the annual meeting of each of the county associations in Hartford, New London, Windham, and Middlesex counties in the odd numbered years.

Par. 5. A Councilor and Alternate Councilor who shall serve for two years shall be elected at the annual meeting of each of the county associations in New Haven, Fairfield, Litchfield and Tolland counties in the even numbered years.

Par. 6. No Councilor or Alternate Councilor elected by a county association shall serve more than three successive terms of two years each in his respective office, but after a lapse of one term of two years such Councilor or Alternate Councilor may be eligible for re-election.

Par. 7. Any vacancy in the office of Councilor or Alternate Councilor shall be filled by the county association in which the vacancy occurs.

Section 2. Duties of Officers

Par. 1. The President shall preside at meetings of the Society, shall appoint all committees not otherwise provided for, shall visit the various medical associations throughout the state and shall present an annual address before the Society at a time to be arranged by the Program Committee.

Par. 2. The duties of the President-Elect shall be to aid and assist the President.

Par. 3. The Vice-President shall assist the President in the discharge of his duties and in the absence of the President or upon his request shall assume the duties of the office. In the event of a vacancy in the office of President, that office shall be filled for the remainder of the term by the First Vice-President. In the event of a vacancy in the office of President-Elect, the First Vice-President shall succeed to that office and the office of First Vice-President shall be assumed by the Second Vice-President.

Par. 4. The Executive Secretary shall attend the meetings of the House of Delegates, shall verify the eligibility and record the presence of members of the House of Delegates and keep minutes of its proceedings. He shall serve as secretary of the Council and keep a record of its proceedings. He shall provide for the registration of members and delegates at the annual sessions; he shall, with the cooperation of the secretaries of the component associations, keep a card index roster of all the legal practitioners of medicine in the State by counties, noting on each his status in relation to his county association, and, on request, shall transmit a copy

of this list to the American Medical Association. He shall cooperate with the officials of the county associations in the extension of the usefulness of the Society. He shall conduct official correspondence of the Society, notify members of meetings, officers of their election and committees of their appointment and duties. He shall make payment of necessary expenditures from funds allocated by the Treasurer and shall employ such assistance as may be approved by the Council. He may, upon request, supply each component association with the necessary blanks for application for membership and with blanks for making their annual reports. In cooperation with a Program Committee he shall publish and distribute all official programs.

Par. 5. The Treasurer shall receive all funds due the Society and shall receive bequests and donations on behalf of the Society. He shall remit periodically to the Executive Secretary and to the Editor of the JOURNAL prorated portions of the funds allocated to these officers for the operation of their offices. All other payments by him shall be subject to a written order of the Chairman of the Council, or in his absence, the President of the Society. The Treasurer shall give bond in a sum and manner of bonding prescribed by the Council. He shall make a report to the House of Delegates at the annual session.

Par. 6. The Managing Editor of the JOURNAL, in addition to the recognized duties of such an office, shall make payment of necessary expenditures from funds allocated to the JOURNAL by the Treasurer. His report of expenditures shall be included in the report of the Treasurer to the House of Delegates at its annual meeting.

Par. 7. The Speaker of the House of Delegates shall preside at all regular and special meetings of the House of Delegates except at such times as he may request the Vice-Speaker to preside during his temporary absence from the chair. He shall cooperate with the Executive Secretary and other officers of the Society in arranging the agenda for meetings of the House of Delegates and he shall appoint reference committees as provided in Article VII and VIII of the By-Laws, or as he may be directed by vote of the House. The Speaker of the House shall have the privilege of voting in the House of Delegates for the purpose of breaking a tie.

Par. 8. The Vice-Speaker of the House of Delegates shall assist the Speaker of the House of Delegates in the discharge of his duties and in the absence of the Speaker, or upon his request, shall assume the duties of his office. In the event a vacancy occurs in the office of Speaker of the House of Delegates, the Vice-Speaker shall succeed to that office until the next annual meeting of the Society.

Par. 9. In the event of a vacancy in the office of Executive Secretary, Treasurer, Managing Editor of the JOURNAL, Literary Editor of the JOURNAL, Vice-Speaker of the House of Delegates, the vacancy shall be filled by a member of the Society appointed by the Council to serve until the next annual or semi-annual meeting of the House of Delegates.

ARTICLE VII

MEETINGS

Section 1. Annual Meetings

Par. 1. The Society shall hold an Annual Session during which there shall be held scientific meetings which shall be open to all registered members and guests.

Par. 2. The time and place for holding each annual session shall be fixed by the Council.

Section 2. Special Meetings

Par. 1. Special meetings of the Society or House of Delegates may be called by the President or by the Council and shall be called by the President on petition of ten members of the House of Delegates or fifty members of the Society.

Section 3. Recommendations

Par. 1. Recommendations made by any scientific session or section meeting may be submitted to the House of Delegates.

Section 4

Par. 1. All resolutions to be introduced before the House of Delegates at an annual, semi-annual or special meeting, except resolutions and recommendations from the Council and resolutions and recommendations that may be contained in committee reports, shall be delivered to the Executive Secretary in time for publication in the official agenda for the meeting at which action is to be taken.

Par. 2. Resolutions and recommendations to be introduced before the House of Delegates at an annual, semi-annual or special meeting by the Council or resolutions and recommendations that may be contained in reports of standing or special committees of the Society shall be published in the official agenda for the meeting at which action is to be taken. The official agenda shall be distributed to the members of the House of Delegates at the earliest possible date preceding the meeting.

Par. 3. Resolutions and recommendations which do not meet the requirements of Paragraphs 1 and 2, of Section 4 of this article may be accepted for action by a session of the House of Delegates by a majority vote of the delegates present. Such resolutions and recommendations shall be referred at once by the presiding officer to reference committees appointed by him from the membership of the House. These reference committees shall consider the resolutions and recommendations referred to them and shall report, with recommendations, to the House before adjournment of the session.

ARTICLE VIII

HOUSE OF DELEGATES

Section 1. House of Delegates

Par. 1. The House of Delegates shall be the legislative and business body of the Society and shall be empowered to carry out the purposes of the Society. It shall consist of the delegates elected by the component county associations and the members of the Council.

Par. 2. Each component association shall be entitled to send to the House of Delegates each year one delegate for every thirty-five members or any additional part of that number. A component county association with less than thirty-five members shall be entitled to one elected member of the House of Delegates.

Par. 3. The presiding officer of the House of Delegates may, in his discretion, appoint committees, to be known as reference committees, from the membership of the House to which business or reports presented before the House may be referred for review and recommendations.

Section 2. Duties

Par. 1. The House of Delegates shall elect delegates and alternate delegates from the Society to the House of Delegates of the American Medical Association in accordance with the constitution and by-laws of that body. These delegates and alternates shall take office on the first of January following their election and shall serve terms of two years.

Par. 2. The House of Delegates shall have authority to appoint committees for special purposes from among the members of the Society. Such committees shall make written reports through the Council to the House of Delegates, and members of these committees may attend meetings of the House of Delegates and participate in the discussion of reports submitted by them.

Par. 3. The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections.

Par. 4. No memorial or resolution shall be issued in the name of the Society without first having been approved by the House of Delegates.

Section 3. Meetings

Par. 1. The Annual Meeting of the House of Delegates shall be called by the Council and shall be held during the week of the Annual Session of the Society. The order of business shall be arranged as a separate section of the program by the Council.

Par. 2. A Semi-Annual Meeting shall be held when required at a place and date to be set by the Council.

Par. 3. Special Meetings of the House of Delegates may be called by the President or by the Council and shall be called by the President on petition of ten members of the House of Delegates or fifty members of the Society.

Par. 4. Twenty-five delegates shall constitute a quorum.

ARTICLE IX

THE COUNCIL

Section 1. Membership

Par. 1. The Council shall consist of one Councilor and one Alternate Councilor from each county association, the President, the President-Elect, the Executive Secretary, the Treasurer, the Managing Editor of the JOURNAL, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, the Delegates to the American Medical Association, any member of the Society who is currently serving as an officer of the American Medical Association, as provided in Article VII, Section 1, of the Constitution of the American Medical Association, and a Councilor-at-large, when elected by the House of Delegates as provided in Paragraphs 2 and 3 of this section. Each member of the Council shall have one vote.

Par. 2. The Council may, in its discretion, recommend to the House of Delegates, at any annual meeting, the election to the Council for a term of one year of any member of the Society who is serving as a general officer of the American Medical Association as defined in Article VII, Section 1, of the Constitution of that Association.

Par. 3. The Council may, in its discretion, recommend to the House of Delegates, at any annual meeting, the election of a Councilor-at-large, who shall serve for a term of

one year. Any member of the Society shall be eligible for nomination to the office of Councilor-at-large.

Section 2. Meetings

Par. 1. The Council shall meet at least every two months throughout the year, except during the months of July and August and September, and at such other times as a meeting may be called by the Chairman of the Council or upon petition of three members of the Council. It shall have its annual meeting for the purpose of organization and election of a Chairman at its first meeting following the annual meeting of the House of Delegates. Eight members of the Council which shall include four Councilors or Alternate Councilors elected by four county associations and four others, shall constitute a quorum for the transaction of business.

Section 3. Duties

Par. 1. The Council shall have the power to act for the House of Delegates between meetings of that body and shall report such actions to the House of Delegates at its next meeting.

Par. 2. The Chairman of the Council and the Councilor from each county shall be the Nominating Committee of the Society. The Chairman of the Council shall be the chairman of the committee. The committee, after consultation and advising with the entire Council, shall report its nominations to the first session of each annual meeting of the House of Delegates. Following this report nominations may be made from the floor.

Par. 3. The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, in relation to other members, to the component associations, or to this Society. All questions of an ethical nature brought before the House of Delegates or a general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component associations on which an appeal is taken, and its decision in all such matters shall be final.

Par. 4. The Council shall serve as a board of review for cases of claimed malpractice referred to it by the Committee on Medical Ethics and Department of any component county association.

Par. 5. The Council shall be the finance committee of the Society and shall superintend and direct all financial transactions of the Society and shall prepare and submit annually to the House of Delegates a budget for the operation of the Society.

Par. 6. The Council shall make an annual report to the House of Delegates.

ARTICLE X

COMMITTEES

Section 1. Standing Committees

Par. 1. The Standing Committees of the Society shall be as follows:

- A Committee on Arrangements
- A Committee on Postgraduate Education
- An Editorial Board of the JOURNAL.
- A Committee on Honorary Members and Degrees
- A Committee on Hospitals

- A Committee on Industrial Health
- A Committee on Medical Education and Licensure
- A Program Committee
- A Committee on Public Health
- A Committee on State Legislation
- A Committee on Public Relations
- A Cancer Coordinating Committee
- A Committee on Professional Relations
- A Committee on Mental Health
- A Committee on Third Party Payments

Par. 2. Unless otherwise specified in these by-laws, nominations for these committees and their chairmen shall be made by the Nominating Committee and presented to the Annual Meeting of the House of Delegates.

Par. 3. All standing and special committees, except the Committee on Arrangements, shall make a written report to the Council before the first of April of each year for transmittal with recommendations to the annual meeting of the House of Delegates. The Council, in its discretion, may request that any standing or special committee make a semi-annual report in writing to the Council for transmittal to the semi-annual meeting of the House of Delegates.

Section 2. Special Committees

Par. 1. Special committees may be appointed by the Council or elected by the House of Delegates as may from time to time be required. Committees appointed by the Council shall make written reports to the Council as directed by it. Committees elected by the House of Delegates shall make written reports to the Council in the same manner as provided for standing committees.

Section 3. Duties of Committees

Par. 1. The Committee on Arrangements shall be appointed by the component association with which the annual session of the Society is to be held. It shall provide suitable accommodations for the meeting places of the Society, and of the special sections, and of the House of Delegates, and of their respective committees. Its chairman shall report an outline of the arrangements to the Executive Secretary for publication in the program.

Par. 2. The Nominating Committee shall nominate to the House of Delegates each year a Committee on Postgraduate Education of not less than seven members and name its chairman. The purpose of the committee shall be to plan and make available programs of postgraduate education for members of the Society, to arrange and conduct the annual Clinical Congress of the Society and to cooperate with university and other agencies within the state for the extension of postgraduate education of physicians.

Par. 3. The Nominating Committee shall nominate to the House of Delegates each year an Editorial Board of the JOURNAL, consisting of not more than fifteen members. One of these shall be nominated as the Managing Editor of the JOURNAL and he shall be a member of the Council also. One other member of the Board shall be nominated as Literary Editor of the JOURNAL and he shall serve as Chairman of the Editorial Board. The Literary Editor, with the active participation and advice of other members of the Board, shall be responsible for the acceptance or rejection of manuscripts for publication and for their literary

quality. He shall not be concerned with the business or financial aspects of the JOURNAL, which shall be the responsibility of the Managing Editor. The remaining members of the Editorial Board shall be selected so far as feasible, to represent the major divisions of medicine, surgery, pediatrics, obstetrics and psychiatry and consideration shall be given to representation from the geographic areas of the state. In addition to the Board so nominated, the President of the Society shall serve as an ex officio member with all rights and privileges of other members during the term of his office. The Editorial Board shall edit and publish the CONNECTICUT STATE MEDICAL JOURNAL and shall determine its advertising policy, all in a manner to promote the best interests of medicine.

Par. 4. The Committee on Honorary Members and Degrees shall consist of the three latest past presidents of the Society. This Committee may present annually to the House of Delegates the names of not more than three eminent physicians as candidates for honorary membership in the Society. The Committee may recommend the bestowal of an honorary degree in medicine upon any person not a physician, distinguished in the sciences of medicine or for contribution in human welfare.

Par. 5. The Nominating Committee shall nominate annually to the House of Delegates a Committee on Hospitals to consist of not less than six members, and shall nominate the chairman thereof. This Committee shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this state and shall, when indicated, confer with the State Department of Health and representatives of the Connecticut Hospital Association and make recommendations to the Society.

Par. 6. The Nominating Committee shall nominate to the House of Delegates annually a Committee on Industrial Health to consist of not less than ten members, and nominate the Chairman thereof. The function of this Committee shall be to inquire into health in industry with the purpose of making information on the subject available to the members of the Society and all other persons interested in improving health and hygiene of persons employed in industry.

Par. 7. At each annual meeting the Nominating Committee shall nominate to the House of Delegates a member of the Society to be proposed to the Governor of the State of Connecticut for appointment as a member of the Connecticut Medical Examining Board for a term of five years in accordance with Section 4365 of the General Statutes of 1930 as amended. During the month of December of each year the Executive Secretary of the Society shall prepare a statement informing the Governor of the Society's choice of a member to be appointed as a member of the Connecticut Medical Examining Board, and, after obtaining the signature of the President of the Society on this statement, it shall be delivered to the Governor. In the event of a vacancy on the Connecticut Medical Examining Board and when it is not practicable to have the choice of another member of the Society who is to be recommended to the Governor for appointment made by the House of Delegates, the President shall propose to the Governor a member of the Society for appointment. The Connecticut Medical Examining Board shall constitute the Society's Committee on Medical Education and Licensure and the President of that Board as elected by its Members shall be the Chairman of

the Society's Committee. The function of the Committee on Medical Education and Licensure shall be to study the educational and legal requirements for practitioners of medicine in the State of Connecticut, to provide information for the members of the Society on these and related subjects, and, as occasion arises, to recommend to the Society amendments to the statutes regulating the practice of medicine within this state and the maintenance of a high quality of medical care in Connecticut.

Par. 8. The Program Committee shall consist of three members, one member of which shall be nominated annually by the Nominating Committee for election by the House of Delegates for a term of three years. The chairman of the Committee shall be the member who is serving the final year of his term of office. The duties of this Committee shall be to arrange the scientific program for the annual meeting of the Society, prepare such a program for submission to the Executive Secretary of the Society for publication not less than two months preceding the date of the meeting.

Par. 9. The Nominating Committee shall nominate to the House of Delegates annually, one member from each component county association and such additional members as it may determine not to exceed fifteen to be the Committee on Public Health and nominate the Chairman thereof. The Committee on Public Health shall be the representative of the Society, in all matters pertaining to public health, sanitation, the prevention of communicable diseases, maternal and infant welfare. It shall confer from time to time with the Connecticut State Health Department and other legal public health authorities in a manner mutually agreeable, and it shall inform the Society concerning matters of public health and, as occasion arises, recommend for the Society's consideration desirable legal enactments to promote public health within the state.

Par. 10. Before the 15th of January of each year, the secretary of each county association, acting on behalf of the association, shall forward to the Executive Secretary of the Society, the name of a member of the county association who is recommended to the Nominating Committee for nomination as a member of the Committee on State Legislation. In addition to these eight members, the Committee shall include the delegates to the American Medical Association and the Executive Secretary, who shall serve as the executive officer of the Committee. The chairman of the Committee shall be designated by the Nominating Committee. The function of this Committee shall be to review and advise the members of the Society concerning proposed state legislation pertaining to the public health, welfare and the practice of medicine. The Committee shall, as occasion arises, draft and have introduced into the General Assembly of this state, appropriate legislation for improving medical care and the public health within the state, advising the Society's legislative agent concerning the opinion of the Society on pending legislation, and supervise and direct the Society's program in the state legislative field.

Par. 11. The Nominating Committee shall nominate to the House of Delegates annually a Committee on Public Relations to consist of eight members and nominate the chairman thereof. The function of this Committee shall be to inquire into and pass upon such phases of public information as deal with the care of the sick and the practice of medicine, and shall endeavor to keep the people of Connecticut accurately and reliably informed concerning mat-

ters of public interest in the field of medicine. The Committee shall use its efforts to encourage cordial relations and understanding with the public press and radio, and co-operate with other committees of the Society in a program of public relations.

Par. 12. The Nominating Committee shall nominate to the House of Delegates annually a Cancer Coordinating Committee and nominate chairman thereof. The membership of this committee shall be not less than seven nor more than nine members and shall at all times include the president of the Connecticut Cancer Society, the chairman of the Connecticut Association of Tumor Clinics and a representative of the State Department of Health. The purpose of this committee shall be to coordinate and integrate the efforts of the various agencies concerned with the study, prevention and treatment of cancer in Connecticut.

Par. 13. At its semi-annual meeting in 1950 each component county medical association shall elect a past president of the association to serve on a state Committee on Professional Relations. The members so elected from the associations in the counties of Hartford, New London, Windham and Middlesex shall serve until the annual meeting of these associations in 1951 at which time the Hartford, New London, Windham, and Middlesex County Associations shall elect a past president to serve on the state Committee on Professional Relations for a period of two years and such elections shall be held biennially thereafter. The members so elected from the associations in the counties of New Haven, Fairfield, Litchfield, and Tolland shall serve until the annual meetings of these county associations in 1952 at which time the New Haven, Fairfield, Litchfield, and Tolland County Associations shall elect a past president to serve on the state Committee on Professional Relations for a period of two years and such elections shall be held biennially thereafter.

No member shall be elected to serve two consecutive terms of two years each, but this restriction shall not apply to the members elected originally at the semi-annual meetings of 1950. No member of the Society who is an elected officer or a member of the Council of the State Medical Society shall be eligible for election to this Committee.

The Committee shall elect its own chairman and recorder and all sessions of the Committee shall be executive sessions and not attended by others except upon invitation of the Committee.

This Committee shall have no jurisdiction in legal actions relating to professional malpractice or negligence. The purpose of the Committee shall be (1) to hear complaints and charges against members of the Society referred to it by county medical associations and, (2) to hear appeals from decisions on charges reached by county medical associations or boards of censors of county medical associations.

When charges against members of the Society are received by the Society's Secretary, either from the public or other physicians, they will be referred at once to the secretary of a county association of which the physician complained against is a member and original jurisdiction in the complaint shall lie with that county association. If in the judgment of the appropriate committee of the county association the complaint should be heard by the state Committee on Professional Relations, it shall refer the complaint to that Committee. The member of the Committee repre-

senting the county association, to which a physician against whom charges have been brought belongs, shall not vote on the final conclusions reached by the Committee.

After a hearing during which the complainant and the physician against whom written charges have been brought shall be given an opportunity to appear, the Committee by ballot shall exonerate or impose such disciplinary action as it may deem appropriate and these disciplinary actions may include reprimand, suspension or termination of membership in the Society. The Committee, upon arrival at a decision, shall notify the physician, against whom charges have been brought (by registered mail) of its findings and disciplinary action to be taken and at the same time, file a resume of its findings and action with the secretary of the county association to which the physician belongs and with the Council of the State Medical Society. A member disciplined by the action of this Committee shall have the right of appeal to the Council before the expiration of 15 days from the receipt of the Committee's findings. In the absence of such appeal, the action of the Committee is final.

Par. 14. The Nominating Committee shall nominate to the House of Delegates annually a Committee on Mental Health to consist of not more than eight members and nominate the chairman thereof. This Committee shall be continually informed concerning the provisions for the care of the mentally ill in the state and those addicted to the use of habit-forming drugs and alcohol with the purpose of making information on these subjects available to the members of the Society and, if indicated, to recommend and support legislation for the improvement of the care of persons in this state so afflicted.

Par. 15. The Nominating Committee shall nominate to the House of Delegates annually a Committee on Third Party Payments to consist of five members and nominate the chairman thereof. The function of this Committee shall be to study existing and projected systems providing payment for physicians' services by any public, private, or cooperative agency, and to advise the Society concerning them. In its operations, the Committee shall confer with representatives of such agencies and other committees of the Society having interest and responsibility in specific phases of medical care that involve payment of physicians by third party agencies.

ARTICLE XI

FUNDS AND EXPENSES

Section 1. Funds

Par. 1. Funds for the operation of the Society shall be raised by an equal annual per capita assessment from each member of a component county association, except:

Par. 2. Members who are elected to the county associations at the semi-annual meetings will be assessed one-half of the annual dues for the year of their election.

Par. 3. Members who have been in good standing in the Society for 40 consecutive years or who have attained the age of 68 and have been members of the Society for 15 years immediately preceding shall be exempt from further payment of dues upon written request addressed to the Treasurer of the Society by the Secretary of the County Association in which the physician seeking exemption is a member and shall continue as active members of the Society enjoying all rights and privileges.

Par. 4. The dues of any member may be remitted by vote of the Council on recommendation of a County Councilor or Alternate Councilor.

Par. 5. All funds of the Society shall be deposited promptly upon receipt in a state or national bank located in the State of Connecticut.

Par. 6. The fiscal year of the Society shall commence on January 1 and terminate on December 31 of each year.

Section 2. Budget

Par. 1. The annual budget of the Society shall be prepared by the Council, as the Finance Committee of the Society, and be presented to the House of Delegates for approval. Based upon that budget the Council shall recommend to the House of Delegates the amount of per capita assessment for the ensuing fiscal year. All requests and resolutions appropriating funds of the Society shall be referred to the Council for recommendation to the House of Delegates and all such requests and recommendations must be approved by the House of Delegates before funds may be expended.

Section 3. Fidelity Bonds

Par. 1. The Council shall prescribe and provide at the expense of the Society proper fidelity bonds for officers of the Society and other persons responsible for the receipt, custody and disbursement of funds belonging to the Society.

ARTICLE XII

REFERENDUM

Section 1. Referendum

Par. 1. A general meeting of the Society may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such questions to the members of the Society who may vote by mail or in person, and, if the members voting shall comprise a majority of all the members of the Society, a majority of such vote shall determine the question and be binding on the House of Delegates.

Par. 2. The House of Delegates may, by a two-thirds vote of its members present, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

ARTICLE XIII

COMPONENT COUNTY ASSOCIATIONS

Section 1. Component County Associations

Par. 1. The County Medical Associations in Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, and Windham Counties now in operation and in affiliation with The Connecticut State Medical Society shall be the component county associations, of this Society.

Section 2. Function

Par. 1. The function of the component medical associations shall be to bring together into one organization the physicians of each county and these associations shall be united for the purpose of organizing the medical profession in the State of Connecticut as provided in Article II, Section 1, of these By-Laws.

Section 3. Eligibility for Membership

Par. 1. All registered physicians licensed under Section 1660c of the General Statutes of the State of Connecticut,

1930, as amended, who have resided and practiced under that license in the State of Connecticut for one year shall be eligible to apply for membership except that student members transferring to active membership as provided in Article V, Section 3, Paragraph 4, shall not be required to reside in Connecticut one year before becoming eligible.

Section 4. Application for Membership

Par. 1. A physician who desires to become a member of a county medical association shall obtain from the Secretary of that association an application form which, when completed, shall be returned to the Secretary. A physician living near a county line may hold membership in that county most convenient for him on permission of the association in whose jurisdiction he resides.

Section 5. Transfer of Membership

Par. 1. A member of a component association of the Society who removes his residence to another county within this state and who wishes to transfer his membership to the county association in the county of his new residence may do so upon the presentation of a certificate signed by the Secretary of the county association of which he is a member. This certificate shall state that he is a member in good standing in the association of the county where he previously resided and that his financial obligations to that association for the current year have been paid. The certificate shall be accompanied by a regular application for membership. The association in the county of his new residence shall add him to the rolls of that association without formality and without charging any dues for the remainder of the year of his transfer.

Par. 2. A member of a state medical society in another state, that is a component of the American Medical Association, wishing to transfer his membership to a component county association of this Society shall present to the Secretary of the component association of this Society in which he is seeking membership a certificate from the Secretary of the county or state medical society of his previous residence. This certificate shall state that he is a member in good standing in that county or state medical association. This certificate and a properly completed application for membership shall be forwarded to the Board of Censors or Credentials Committee of the component association in this state in which he is seeking membership and that Board of Censors or Committee on Credentials may recommend his election at the next meeting of the component association without regard to the residence requirement prescribed in Section 3 of this Article.

Section 6. Membership Roster

Par. 1. The Secretary of each component association shall keep an individual record of the members of that association, and this record shall include the full name, address, college degrees with year, medical schools attended with school and year of graduation, hospital affiliations, type of special practice, if any, and date of registration in this state. Notations shall also be made concerning transfer and termination of membership.

Section 7. Discipline

Par. 1. Any member of a component county association who is aggrieved by disciplinary action of the county association of which he is a member shall have the privilege of appealing to the Council of the Society which shall review

the charges made against the disciplined member and the findings therein and render a decision concerning the disciplinary action taken; this decision shall be final.

Section 8. Termination of Membership

Par. 1. When membership in a component county association terminates for any cause, membership in the Connecticut State Medical Society shall be terminated automatically as of the same date.

Section 9. Delegates to the House of Delegates of the Society

Par. 1. Each component county association shall be represented in the House of Delegates of the Society on the basis of one delegate for each thirty-five members and any additional part of that number. Component associations with less than thirty-five members shall be entitled to one elected delegate.

Par. 2. On or about the 15th of March of each year the Executive Secretary of the Society shall inform the Secretary of each of the component associations of the number of members in good standing in each component association on the 31st of December just preceding, and compute therefrom the number of delegates to which each county association is entitled for the ensuing year.

Par. 3. At least twenty days prior to the annual meeting of the House of Delegates the Secretary of each component association shall inform the Executive Secretary of the Society of the names and addresses of the officially elected and qualified delegates from each county association.

Par. 4. In case of the inability of a regularly elected delegate to attend meetings of the House of Delegates, the President or the Secretary of the county association in which the vacancy occurs shall appoint an alternate delegate, with full power to represent that county association during the interim, or until the successor of such regularly elected delegate is elected. Upon the appointment of such alternate delegate, the Secretary of the county association in which the appointment is made shall inform the Executive Secretary of the Society of the appointment at once, and before the alternate delegate may be seated in the House of Delegates.

Section 10. Dues

Par. 1. Any of the component county associations may at its option collect the annual dues assessed by the Society in conformity with regulations established by the Treasurer of the Society. Bills for these dues shall be rendered to all members immediately following January 1 of each year and the component county associations shall forward all monies so collected on behalf of the Society to the Treasurer of the Society quarterly and at such other times as the Treasurer may direct and they shall accompany all payments with a report on a form to be provided by the Treasurer.

Par. 2. If a component county association does not elect to collect the annual dues assessed by the Society as provided in Paragraph 1 above, the Treasurer of the Society shall collect the annual dues assessed by the Society from the members of that component county association and collect also the dues assessed by that county association. In that event the Treasurer of the Society shall remit to the county association periodically all monies collected on behalf of that association and shall file an accounting of all county association assessments so collected for the year just closed

with the county association before the 15th of January of each year.

Section 11. By-Laws

Par. 1. The component county associations shall have the power to adopt only such by-laws as are not in conflict with the by-laws of The Connecticut State Medical Society. In the event of an existing or apparent conflict the by-laws of the Society shall take precedence over those of a component county association.

ARTICLE XIV

AMENDMENTS

Section 1. Amendments

Par. 1. The by-laws of the Society may be amended by a majority vote of the total number of the members of the House of Delegates.

Par. 2. Proposed amendments to the by-laws shall be submitted first to the Council and published, with the Council's recommendation, in the CONNECTICUT STATE MEDICAL JOURNAL at least one month prior to the date of the meeting of the House of Delegates at which action thereon is to be taken. Copies of the proposed amendments shall also be forwarded to each member of the House of Delegates in the notices of the meeting at which the amendments are to be acted upon.

ARTICLE XV

PARLIAMENTARY PROCEDURE

Section 1. Rules of Order

Par. 1. In all matters of parliamentary procedure the Society shall be governed by Robert's Rules of Order.

Section 2. Enablement Clause

Par. 1. The adoption of these by-laws rescinds and revokes all previous by-laws of the Society and supercedes their operation.

Meetings Held During January

- January 5—Connecticut Health League
Connecticut Medical Examining Board
- January 6—Conference on Pediatric Extension Courses
- January 7—Fellowship Awards Committee—Connecticut Cancer Society
- January 10—Board of Directors—Connecticut Medical Service
- January 12—Connecticut Health League
Advisory Committee to State Welfare Department
- January 18—Board of Directors—Woman's Auxiliary
- January 19—Subcommittee on Insurance Council
Committee on Maternal Mortality and Morbidity

THE HISTORIAN'S NOTE BOOK

A CASE OF GANGRENE OF THE LEG, 1742

ARTHUR S. BRACKETT, M.D., *Riverside*

HUXHAM was writing on the State of the Blood . . .
which he thought caused Gangrene.

The Fever, which attends Gangrene, is commonly of this Kind, corrupting and dissolving the Blood; the sanious Matter of the gangrened part, being resorbed into the Mass of Blood, produces a universal gangrenous Disposition in the Humors, and dissolves the sound red Globules; whence Spots, Hemorrhages, black Tongues, Delirium, &c supervene . . . I will instance but one Case which I think is uncommon in several Circumstances.

Mrs. Elizabeth S—th . . . about 25 . . .
of a weak Constitution . . . and bad habit of
body . . . was taken . . . in May 1742
with a pain in the right Foot near the toes, and with
“Torpor” all over the Leg; which hourly increases,
she sent for a surgeon who rubbed the Part with
camphorated Spirit of Wine, and formented it with
a very warm aromatic Decoction; not withstanding
the part grew discolored, cold and quite insensible.
When I came I ordered the Parts to be scarified
. . . only a few Drops of the black Blood ap-
peared.

The Leg looked as if it had been cut off for some
Days . . . tho’ this was but in the Forenoon of
the “forth Day” from the first Seisure. . . . no
Matter, Stench, or “Sanies.”—I immediately ordered
her the “Bark” with “Elixir Vitriol” . . .
with a warm acidulated Julep, . . .—A violent
Pain seized her in the afternoon in her right Thigh
and Groin . . . Fever . . . griping and a
bloody Flux came on . . . causing perpetual
Faintings and Agonies.

The ensuing night she grew delirious, her Tongue
quite black and faltering . . . her pulse weak
. . . with continual Catchings of the Tendons

In this miserable Condition she continued for four
Days, Everyone expected her hourly Death . . .
However the “Sphacelation” did not advance: &
never appeared above the Knee, tho’ a very vehe-
ment Pain affected the whole Thigh, and seemed
chiefly in the “Periosteum” of the Bone. At length
there appeared a dark livid “Streak” all around the
Limb . . . under the Knee where Nature was
disposed to separate the dead Part from the living.
. . . This Tendency to Separation became every-
day more and more visible and the Surgeon used
every proper means to promote it. . . .

She and her friends would not have an amputation.
. . . She continued in these deplorable Circum-
stances till July 14th when the Surgeon finding the
“Slough” cast off and the separation at the Joint
almost perfectly made, took off with a Knife the
dead Leg from the sound Thigh, at the “very Artic-
ulation,” with very little pain, without her consent
and almost without her knowledge.

Soon after this she daily recovered and by proper
Diet and Medicines was in a little time restored to a
tolerable State of Health.

I thought it would be interesting to see what our
surgeons would think the trouble was—reasoning
from Huxham’s account of the case.

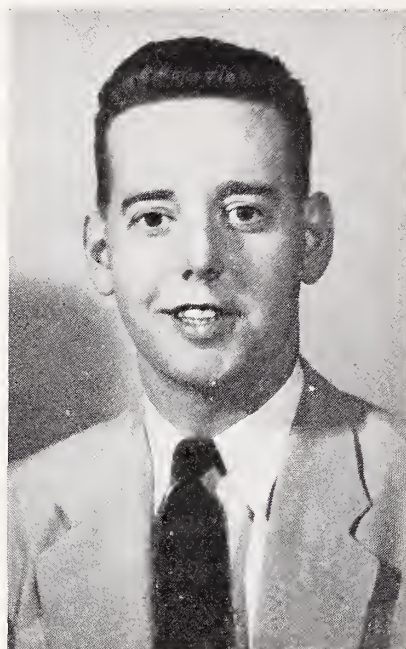
So I wrote Dr. Gustaf E. Lindskog of the Yale
University School of Medicine and Dr. Philip S.
Brezina, surgeon on the staff of the Bristol (Con-
necticut) General Hospital. Both agreed that it was
an embolus probably from the heart.

Huxham was in favor of amputation in spite of the
pain and shock which would come from such an
operation, without anesthesia.

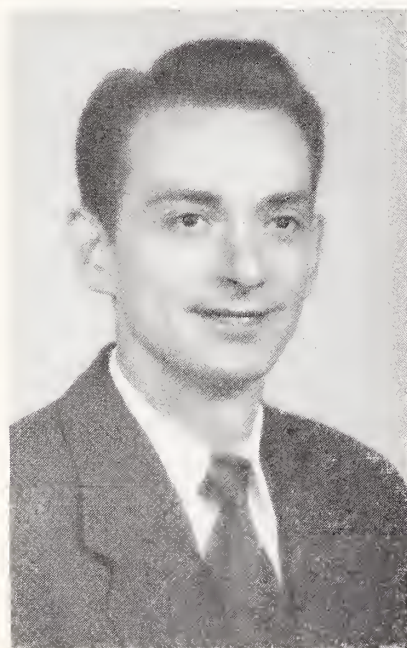
MEDICAL STUDENTS WHO RECEIVED THE SOCIETY'S 1954 SCHOLARSHIPS



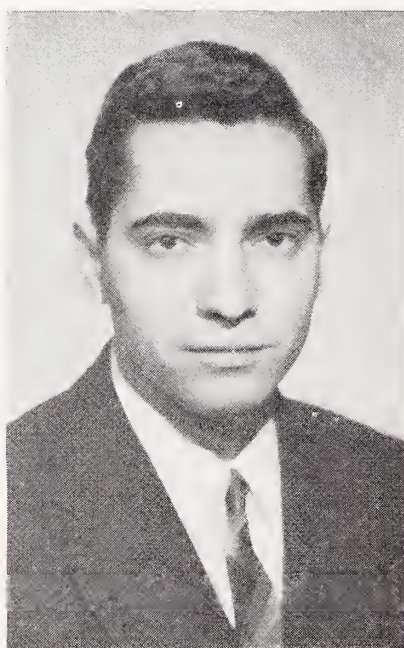
WILLIAM VOUNATSO
Residence: Hartford
Medical School: University of Pennsylvania
School of Medicine



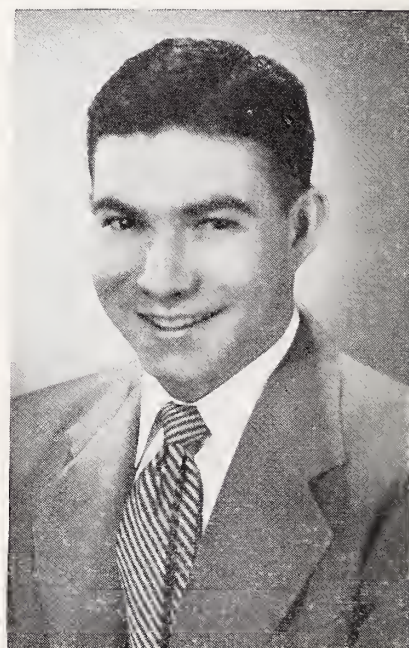
ARTHUR J. MCPADDEN, JR.
Residence: Bridgeport
Medical School: University of Vermont
College of Medicine



DANIEL LION
Residence: New Haven
Medical School: State University of
New York College of Medicine



EDWARD D. COPPOLA
Residence: Waterford
Medical School: Yale University
School of Medicine



ROBERT GOYER
Residence: Collinsville
Medical School: St. Louis University
School of Medicine

Yale to Receive \$3,160,000 For Research in Biophysics

The John A. Hartford Foundation has awarded Yale University a grant of \$3,160,000 for research and training in biophysics and the construction of a new research laboratory.

Yale will receive this \$3,160,000 in the form of an annual grant of \$180,000 for the next 15 years, plus \$460,000 for construction of the new laboratory.

The new 10,000 square foot biophysics research laboratory will be located on the Hartford Foundation's property in Valhalla, N. Y., two miles north of White Plains, N. Y. The instructional phase of the new biophysics program will be centered in New Haven, while research activities will be conducted both at Yale and Valhalla.

The Foundation was established by the late John A. Hartford who was president of the Great Atlantic and Pacific Tea Co. Last spring the Foundation made a grant to the Yale University School of Forestry for a vast new program of research and education in forest biology. The research phase of this forestry program will also be conducted in large part at Valhalla.

Ernest C. Pollard, professor of biophysics at Yale, a leading figure in this recently developed science, will be chairman of a new Department of Biophysics. Until now, biophysics at Yale has been predominantly a part of the Physics Department.

Franklin Hutchinson, assistant professor of radiation physics at Yale, will be resident director of the Biophysics Research Laboratory at Valhalla next year. The position of resident director of the laboratory will be filled on a rotating basis.

During a half-year leave of absence from Yale starting next February 1, Prof. Pollard will spend some time at the Hartford Foundation's house on its Buena Vista Farm in Valhalla. This house will be used as the library and living quarters for the biophysics laboratory staff.

While there Prof. Pollard will work with Andrew E. Euston, New Haven architect, drawing up plans for the new research laboratory at Valhalla. No construction date has been set at this time. Prof. Pollard will spend the remainder of his leave studying biophysics at the Radiological Research Unit of the Mount Vernon Hospital and Radium Institute

in London, England, where he will work with Dr. L. H. Gray.

Instructional headquarters of the new program will be located in the new science laboratory for biology and physics research currently under construction at Yale on Pierson-Sage Square. The number of graduate students in biophysics will be increased, as will the number of undergraduates majoring in this subject.

The new biophysics laboratory at Valhalla, in addition to being the center of a research program, will also be used for conference and seminar purposes as well as for summer studies. The first conference on the Physics of Cellular Processes was held at Valhalla on January 25, 26 and 27.

Dr. Gibson Named Acting Director of Bradley Home

Dr. Cole B. Gibson has been appointed acting director of the Bradley Home to take the place of Howard E. Houston, who has resigned to accept the post of deputy director of the federal Foreign Operation Administration's mission in India.

Mr. Houston, former mayor, was the first superintendent of Bradley Home, assuming his duties in 1935 when the home was first established.

Dr. Gibson retired from Undercliff on June 30 of this year. He first came to Undercliff on March 17, 1917, when the institution had been established only eight years. Dr. Gibson was named superintendent there November 1, 1919.

Born in Saluda, S. C., Dr. Gibson was educated at Emory University in Atlanta, Georgia, and received his M.D. from Atlanta Medical College in 1914. He has received many professional honors including a fellowship in the American College of Physicians, diplomate of the Board of Internal Medicine, fellow of the American College of Chest Physicians.

As medical director at Undercliff, Dr. Gibson was also administrator of the institution, thereby taking to the Bradley Home a wealth of experience. He has been active over the years with the Meriden Hospital, serving as secretary of the Board of Directors. He is secretary of the New Haven County Medical Association, and is a former president of the State Medical Society and speaker of the house of delegates.

NEWS FROM WASHINGTON

PRESIDENT EISENHOWER REQUESTS TWO YEAR EXTENSION DOCTOR-DRAFT LAW

Major Medical Legislation in the Next Congress

FINANCING OF MEDICAL CARE

Reinsurance. The administration will propose a reinsurance bill, probably one that closely follows the lines of the bill defeated last year; it is likely to define specific areas where reinsurance could be helpful, such as catastrophic coverage, chronic illness, etc.

Assistance to the indigent. There are plenty of indications that bills to extend coverage to the indigent and the medically indigent will be proposed and pushed hard in Congress; subsidies to States to help finance health insurance for low income groups are a possibility. The administration may have its own bill or bills in this field.

U. S. employee health insurance programs. Last touches are being put on a revised bill providing for U. S. contributions and payroll deductions. This is a major administration health proposal.

Mortgage guarantee for health facilities. This proposal (the Wolverton-Kaiser plan) was the subject of hearings last session. It did not have administration support and lost in committee. But it will not be unexpected if a similar proposal comes out as an administration bill this session.

AID TO MEDICAL EDUCATION

Nothing was done in this direction in the last Congress, but all indications are that this subject will be an important one in this Congress. The question here is how far the federal government should go. There probably would not be strong objection to grants for renovation, new construction and equipment. If the bill proposes grants for maintaining medical schools, strong opposition is likely from the medical profession in the fear that the federal government ultimately would dominate medical education. The administration may include an aid-to-medical education bill in its program for this session.

VETERANS' LEGISLATION

The usual number of bills are expected, all directed toward easing eligibility requirements for medical care of veterans. There is no indication which the administration will support, if any, nor whether the bills will fare better in a Democratic than a Republican Congress.

PUBLIC HEALTH GRANTS

Last session an administration bill for revising the system for allocating U. S. funds to the States for public health work passed the House but died in the Senate committee. The purpose was to eliminate categorical grants, giving State health officers more control over federal funds. A revised bill will be introduced.

MENTAL HEALTH PROGRAM

A movement is under way to broaden research into mental illness as well as to provide more facilities. Mental cases are the most costly phase of medical care to all States, and facilities are said to be inadequate. Furthermore, it is pointed out that if treatment can be made more effective, many thousands of mental patients will be returned to society. Congress will be asked by a number of groups to do something in this field.

Military Medicine

DOCTOR DRAFT

The Doctor Draft is scheduled to expire next June 30. Dr. Frank Berry, Assistant Secretary of Defense for health and medical matters, believes an extension is necessary. This attitude seems to govern the military, despite the announced plan for cutting the strength of the Armed Forces by 403,000 men in the next 18 months. If the Doctor Draft is not extended, (and assuming the regular draft is extended) the military requirements will be met by nonveteran interns, and men who join up for a career. This will meet the present needs but does it plan for the future? We cannot cut down all the young trees

and then a few years later expect to reap a mature crop. The opposite position is that the draft should be used to the extent necessary so that sufficient physicians may receive residency training following their internship, thus assuring that the specialty needs of the services may be met several years in the future. Only by this means can a continued flow of young specialists be provided for the services. In order to do this, at least one thousand interns each year should be deferred for residency training, with an obligation to enter the services following this period of training. Only by following such a procedure will it be possible to end the draft.

NATIONAL RESERVE PLAN

Similar to the Universal Military Training Program twice defeated in Congress. The Administration will press hard for this bill. Some 100,000 youths between 17 and 19 would receive six months of extensive training each year, then have 9½ years of reserve obligation. For the man planning a career in medicine, six months of military training would be followed by deferments for premedical, medical and intern training, provided he attended weekly drill and summer camps. Satisfactory completion of reserve training could reduce total time from 9½ to 7½ years.

DEPENDENT MEDICAL CARE

A bill similar to the one offered last year will be presented. It will call for a more uniform system of medical care for military dependents, with the military services themselves taking care of all dependents they can. The Government would arrange with private sources for the care of the remaining dependents. Mr. Eisenhower is firmly behind the principle of improving the care offered military dependents.

MILITARY MEDICAL SCHOLARSHIPS

A bill was prepared last session, but not introduced. It will be offered this session. A limited number of medical students would get full scholarships. They would repay this by military service, with one year for each scholarship year, but minimum service of three years.

Tax Postponement for Self-Employed

This legislation (Jenkins-Keogh) would allow physicians and other self-employed to defer income tax payment on a part of their income to be put into restricted annuity programs. The Treasury Department, which was not sympathetic to the bills offered last year, is now showing some interest in the Ray

bill (HR9618) which is basically the same but which offers tax deferment benefits to all persons, and has tighter restrictions on the portion of income that may be set aside. A significant development is a U. S. Circuit Court decision (Kintner, CA-(9) 10/14/54) which, under certain circumstances, would allow physicians in group practice to benefit from retirement funds financed by the group. The Administration is accepting this decision and is not taking it to the Supreme Court.

Bricker Amendment

Senator Bricker again will propose his constitutional amendment, which would: (1) prohibit treaties made in conflict with the Constitution, (2) make a treaty ineffective as internal law without legislation that would be valid without the treaty, and (3) require a roll call vote for ratification. The amendment resolution lost last year in the Senate, but a one-vote shift would have given it the required two-thirds. The medical profession is interested in the amendment because under present law socialized medicine could be imposed through international treaty or agreement without being considered by the House and Senate. The U. S. Supreme Court has under advisement a case (U. S. vs. Guy W. Capps) that could have an important bearing on the problem. The case concerns an executive agreement between the U. S. and Canada.

Defense Announces Residency Deferment for 300 Physicians

A total of 300 interns have been selected by the Defense Department for deferment for one-year residencies in 15 medical specialties essential to the military departments. The names were drawn by lot from among more than 1,300 nonveteran interns who asked for further deferment under the new Armed Forces Reserve Officer Commissioning and Residency Consideration Program announced last September.

Under the Defense Department-Selective Service program, questionnaire statements of service preference were sent all 1954 medical school graduates who had been deferred from induction to complete their medical education plus one year's internship. Of the more than 1,800 replies, some 1,300 asked for residency deferment, while 560 preferred to accept reserve commissions and enter their two-year tour of duty within the year following completion of internships next spring.

The 300 physicians selected for residency defer-

ment in the hospital of their choice are to be divided equally between the Army, Navy and Air Force reserves. The remaining 1,000 interns who failed to be selected are subject to induction after next June under either the regular draft or the doctor draft, depending on what action the next Congress takes on the law. Both the regular and the doctor drafts expire June 30.

Actually the armed forces would like to have considerably more than 300 set aside for the residency pool but that figure was regarded as the maximum which could be spared from military activation in 1955. Inasmuch as these selectees will be distributed among 15 specialties, for hospital training purposes, it is evident that they will fall far short of meeting military needs.

Physicians Through 37 Being Examined for Doctor Draft

To meet the Defense Department call for 1,275 physicians for induction next March, draft boards have started processing men through the age of 37. Selective Service headquarters instructed boards to call up for examination those priority 3 physicians born on or after January 1, 1917, where previously the cutoff birth date was August 30, 1922. To meet defense quota of 459 dentists in March, priority 3 registrants born on or after January 1, 1910, are being examined. In the case of both physicians and dentists, priority 1 of all ages and priority 2 men without restriction as to months of service also are being used for the March call.

Regulations Adopted for New Hill-Burton Program

To be officially promulgated this week, by publication in Federal Register, are regulations governing operation of a broadened Hill-Burton program. These "ground rules" are of vital importance to institutions and organizations contemplating construction or expansion of outpatient clinics, chronic disease hospitals, nursing homes and rehabilitation facilities. For current fiscal year, ending June 30, 1955, \$21 million in Federal grant money is available. The new regulations go into effect January 12, six months after the enabling act was signed. Main features are as follows:

OUTPATIENT FACILITIES

Each State will be permitted to have no more than one per 10,000 population, the size or capacity of

the center not being taken into reckoning. Federal grants are limited to public agencies or nonprofit groups operating hospitals; they may not be made to a doctors' group planning to operate initially on a nonprofit basis and then, after a successful practice is developed, rebate the Federal grant money. Construction priority will be on a community, rather than an area, basis to provide greater degree of flexibility. Coordination with existing and proposed hospitals is desirable.

REHABILITATION CENTERS

To qualify for aid, they must offer "integrated services" for one or more types of disabilities. Physical, mental, social and vocational handicaps are recognized. The allowance ratio, per State, is one center per 300,000 population. Priority will be higher for projects in population centers and in proximity to medical centers.

NURSING HOMES

These must be hospital-affiliated or under general medical direction. No nursing home with fewer than 10 beds will be eligible for aid unless it is a subunit or part of a hospital. The State allowance ratio is a maximum of three beds per 1,000 population. However, in interest of flexibility, States may have up to a 4/1,000 ratio if their chronic hospital and nursing home beds combined do not exceed 5/1,000.

Regulations affecting chronic hospital beds (ceilings, distribution, etc.) are unchanged, save that osteopathic staffing is clarified. Recognition of DO's also is made clear where the three new categories are concerned. Another point common to all four types of facilities is that, although community service is stressed, segregation is allowed in States whose plans provide for all elements of the population. Interstate agreements for joint sponsorship of projects are permissible.

Six Additional Insurance Companies Cited by FTC

Six more insurance companies selling accident and health policies have been accused by the Federal Trade Commission of using false and misleading advertising. Shortly after the complaints were filed a statement issued on behalf of the companies noted that the complaints are not a finding or a ruling, and that they were issued while the companies were co-operating with the commission in investigating practices in the industry.

The companies named are: Sterling Insurance Co., Chicago, Illinois; Combined Insurance Company of

America, Chicago; Professional Insurance Co., Jacksonville, Florida; Service Life Insurance Company, Omaha, Nebraska; Postal Life and Casualty Insurance Co., Kansas City, Missouri; and Guardian Insurance Co., Dallas, Texas. Last fall 17 other insurance companies were named in similar charges by the FTC.

HEW Naming Public Committee to Study Food and Drug Operations

A special committee made up of representatives of the food, drug and cosmetic industries plus "outstanding citizens" from other groups soon will be appointed to make a broad survey of the Food and Drug Administration and later recommend any changes in the operation of the agency. This was disclosed by FDA Commissioner George Larrick in an address to the American Pharmaceutical Manufacturers Association. He said some of the questions to be answered were: What level of inspection is desirable? What programs should receive greater emphasis? What work can be left to the States? Commented Mr. Larrick: "We sincerely hope that this committee will be able to point the way toward a real improvement in our service to the American people."

The FDA commissioner also made these points: (1) the agency cannot do a 1955 job with a 1940 staff and (2) fake medical products and devices are increasing as sufferers from chronic ailments continue to be the victims of "high powered hocus pocus research." Mr. Larrick said the most serious and most tragic exploitation is in the field of cancer quackery, and that operators in this field are attacking the medical profession. Medical quackery, he added, is using the "big lie" technique to cloak its operations in the guise of legitimate research.

\$10.2 Million Grants Approved for Research

Public Health Service has announced approval of grants totaling \$10,275,533 for support of 972 medical research projects. Awards were based on recommendations made to Surgeon General Leonard A. Scheele following October-November meetings of the seven national advisory councils to National Institutes of Health. The sum represents approximately 30 per cent of the \$33.9 million appropriated by Congress for assistance to medical research in fiscal year ending June 30, 1955.

CATEGORICAL ALLOCATIONS

Cancer and heart research grants account for about 60 per cent of the funds awarded, former

totaling \$3,564,830 (279 projects) and heart investigations receiving \$2,541,976 (258 projects). The others: Arthritis and metabolic diseases, 107 projects, \$998,703; neurological diseases and blindness, 84 projects, \$889,860; dental research, 11 projects, \$84,074; infectious diseases, 42 projects, \$360,739; mental illness, 69 projects, \$782,643; noncategorized research, 122 projects, \$1,052,708.

For continuation of existing research projects (683), grants totaled \$7,195,693. Approval was given 289 new investigations, aggregating \$3,079,840 in awards. Recipients will do their work in 215 institutions, including one each in Argentina, Denmark, Canada and India.

Among the grantees: Dr. Louis N. Katz, Michael Reese Hospital, Chicago, four heart disease projects, \$60,000; Dr. James A. Reyniers, Notre Dame University; germfree animals, \$28,000; Dr. Charles A. Hufnagel, Georgetown University Hospital, heart surgery, \$11,895; Dr. Arthur J. Vorwald, Wayne University, experimental pulmonary cancer, \$24,437; Dr. Irving S. Wright, Cornell, cerebral thrombosis, \$10,000; Dr. Esmond R. Long, National Tuberculosis Association, tuberculous meningitis prophylaxis, \$55,629; Dr. Howard A. Rusk, New York-Bellevue, rehabilitation of the chronic rheumatoid arthritic, \$22,500.

Part-Time Fellowships Evoke Hearty Response

Medical and dental deans have responded enthusiastically to new Federal program for financial aid of students interested in research. Less than two weeks after its announcement, four dental schools applied for part-time fellowship stipends. And to date 66 medical schools have entered the program, less than five months after NIH Division of Grants and Fellowships invited participation of all schools of medicine (including the 2 year basic science schools).

Each medical school may appoint four part-time research fellows and dental schools, two each. Stipends are uniformly \$400, with 8 per cent added for overhead expenses. The school's sole obligation is, at close of year, to report names of appointees, amount of funds expended and file a brief description of the student-fellow's research activities.

Rockefeller Moves to White House

Appointment of Nelson A. Rockefeller as special assistant to the President in charge of coordinating all Federal programs to develop "increased understanding and cooperation among all peoples" was

announced by Mr. Eisenhower on December 16. Mr. Rockefeller relinquishes his job as Under Secretary of Health, Education and Welfare, a post he has held since June 1953.

Rep. Dingell Introduces National Health Insurance

In January, 1953, Rep. John Dingell (D-Michigan) waited until 83rd Congress was nearly two weeks old before reintroducing his compulsory national health insurance bill. But before the 84th was fully one day old he dropped HR95 into the hopper. It is no different from 1953's HR1817, with its provisions for subsidized medical education, research, hospital construction, public health, maternal and children's health programs, etc., as well as government health insurance.

Although there is scant likelihood of the omnibus bill's making any headway whatever this year, Rep. Dingell's fierce opposition to the President's reinsurance scheme—which the Michigan Congressman brands as the real stepping stone to socialized medicine—will not make its path any smoother when legislative consideration begins.

This week Rep. Dingell is expected to reintroduce another controversial bill, authorizing payment out of the social security trust fund of hospitalization expenses incurred by recipients of old age and survivors insurance and their dependents. He also will push for an amendment to establish disability insurance (WRMS No. 387).

New Medical Office Building in Bridgeport

Bridgeport will have a new one million dollar office building known as Medical Center, Inc., constructed this year on Washington Avenue. The building will be five stories high and enclosed almost entirely in glass and will be owned by 50 physicians from the three Bridgeport hospitals. A cross section of doctor-investors will occupy most of the offices, while some will be available also to dentists.

An outstanding feature will be parking space for 200 cars. The building will have covered or sheltered entrances on three sides. It will be 125 × 80 feet, will be completely modernistic and will be air conditioned and serviced with elevators.

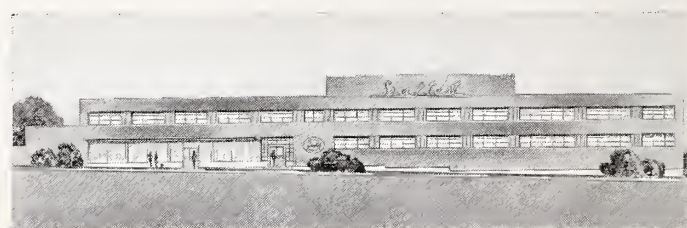
Bryant & Chapman Enlarges Hartford Plant

\$1,600,000 will be spent by Bryant & Chapman in tripling the size of its Sealtest dairy plant on Homestead Avenue in Hartford. Construction has already started and it is expected that the new processing and distributing plant will be ready for occupancy in the autumn of 1955.

Byant & Chapman's original building on this same site was erected in 1910 by Willard M. Bryant and Bert W. Chapman, who pioneered in selling pasteurized milk and cream in Hartford.



Photograph taken in 1912 of the Bryant & Chapman dairy at the corner of Homestead Avenue and Woodland Street in Hartford



Homestead Avenue view of new Bryant & Chapman Sealtest dairy plant in Hartford, to be completed late in 1955

The new dairy plant will be completely air conditioned and constructed of steel framing, red brick, and aluminum for windows, frames and trim.

Byant & Chapman, which also operates distributing branches for Sealtest dairy products in Manchester, Melrose, New Britain and New London, is a subsidiary of the General Ice Cream Corporation.

MORE THAN 103,000 PHYSICIANS

Today's Health, popular educational magazine published by the American Medical Association, is now available to patients in the reception rooms of more than 103,000 physicians.

The Woman's Auxiliary to the Connecticut State Medical Society sponsors subscriptions to this leading health magazine. It is available to physicians at half the usual rate and may be obtained by using the coupon on this page.

Connecticut State Medical Society
160 St. Ronan Street
New Haven 11, Connecticut

Please enter my subscription to *Today's Health* at the special physician's rate—four years for \$4.00; three years for \$3.25; or one year for \$1.50.

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- Send bill with first issue ☐

Signed:
Office Address
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PUBLIC RELATIONS

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New Yale Course on Medical Economics and Public Relations

A new course on the economics and relationships of modern medical care was inaugurated January 6 at the Department of Public Health, Yale University School of Medicine, in cooperation with the State Medical Society.

At the first session, Dr. Thomas P. Murdock, Meriden, member of the Board of Trustees of the American Medical Association, addressed a class of 50 medical students and students in public health on the expanding services of medical associations and increased demands for medical care.

The course is one of the first of its type to be offered to medical students. Proposed by the Society's Committee on Public Relations and approved by the Council, the course was arranged by Dr. Creighton Barker, executive secretary of the Society and Dr. Ira V. Hiscock, chairman of Yale's Department of Public Health.

The course is open to medical students, graduate students in public health, law students and physicians.

Content of the new lecture series was developed by consulting practicing physicians concerning the type of information their experience has indicated would be most useful for young physicians entering practice. The information also will prove useful for students who plan a career in public health and for law students who may later require medical testimony in legal cases.

The classes are held each Thursday at 4 P. M. in Farnum Auditorium. At the January 13 session, Dr. Barker spoke on procedures for medical licensure and factors to be considered in starting a medical practice.

Dr. Alfred J. Sette, Stamford, addressed the students on "Physician-Patient Relationships" at the January 20 session. Dr. William H. Horton, Windsor, executive director of Connecticut Medical Service, was lecturer on January 27 and Dr. Charles

G. Hayden, Boston, executive director of Massachusetts Medical Service, lectured on February 3.

Both speakers discussed "third party relationships," including the relationships of physicians with hospitals, public health departments, community organizations, insurance carriers, voluntary health insurance plans, welfare departments and state and federal agencies.

Dr. Robert Jordan, New Haven, and Dr. Harry C. Knight, Middletown, will share the topic "Types of Medical Practice" on February 10 and February 17, respectively.

On February 24, Professor George Dession, New Haven, Lines Professor of Law, Yale University Law School, will speak about the legal requirements of medical testimony and on March 3 the course will conclude with a discussion of the costs of establishing and maintaining a medical practice and physician income by William Alan Richardson, Darien, editor of *Medical Economics*.

New Report on Magazine and Television Medical Information

"This Month in the Magazines," a review of medical articles appearing in national magazines, has been incorporated by the Public Relations Department, AMA, with medical television news.

Titled, "Magazine-Television Report," the new combined review of both media, will be published weekly in the *Journal of the American Medical Association*. Publication began in the January 1 issue of the *Journal*, page 68.

First Aid Charts Now Available

The First Aid Charts published by the Society's Public Relations Committee in cooperation with the Woman's Auxiliary, are now available for distribution through physician's offices. They may be obtained at the offices of the State Medical Society upon payment of \$3 per 100 copies which amount covers only the charges for printing and mailing.

The chart measures 12 × 15 inches and is printed in red and black on white stock. It may be hung on a wall or attached inside the door of a medicine cabinet.

Educational Film Shown at Three High Schools

The educational 16 mm. sound film, "Your Doctor," has recently been shown before three more audiences of high school students. At the Seymour High School and the Annex School in that community, the film was seen by approximately 275 students. The film also was viewed by an audience of 700 students at the Berlin High School.

Copies of the film are available for showing before community groups without charge. Produced by RKO Radio Pictures and the American Medical Association, the production portrays the story of medical education and medical practice in urban and rural communities.

Junior Chamber of Commerce Sponsors Community Health Week

Medical societies throughout the country are co-operating with the Junior Chamber of Commerce in planning for the observance of a community health week to be held March 21 through March 27.

In Connecticut, plans are being developed with State officers of the Chamber to encourage activity in as many communities as possible. Since the observance of community health week would directly involve the medical profession, it is planned to request the cooperation of county and local medical societies in the program. The observance is aimed at enlisting 180,000 young businessmen in 2,800 communities in activities which will bring them first-hand knowledge of their community health resources.

Dr. Murdock Heads Special AMA Committee

The Board has appointed a special committee, headed by one of its own members, Thomas P. Murdock of Connecticut, to re-evaluate the existing seal-acceptance programs of the scientific councils of the American Medical Association. It is believed that a program can be devised which will make the services of the Association even more valuable to the profession and the public than is now the case. The committee will report to the Board in February.

Invitation To All Connecticut Physicians to Join the Connecticut Committee on Trauma of the American College of Surgeons

Meetings now scheduled include March 16 in Waterbury at 8:00 P. M., Waterbury Medical Society meeting topic: "Conservative Treatment of the Low Back;" April in New London, "Recent Advances in Industrial Atomic Medicine;" October, Trauma Session at the Meriden Hospital, program to come later.

New roster will be made up if enough new members enroll. Membership fee \$3.

Simply send \$3 with name and address to Luther W. Strayer, Jr., M.D., 144 Golden Hill Street, Bridgeport, Connecticut.

See editorial page, this issue, for aims and purposes of the Connecticut Committee on Trauma of the American College of Surgeons.

THE DOCTOR'S OFFICE

James L. Callahan, M.D. announces the opening of an office for the practice of surgery at 50 Farmington Avenue, Hartford.

Martin E. Gordon, M.D. announces the opening of an office for the practice of gastroenterology at 111 Sherman Avenue, New Haven.

Nicholas A. Giosa, M.D. announces the opening of an office for the general practice of medicine and obstetrics at 559 Hillside Avenue, Hartford.

William R. Maniatis, M.D. announces the opening of an office for the practice of surgery at 881 Lafayette Street, Bridgeport.

James V. Macgregor, M.D. of London, England, announces the opening of an office for the practice of general medicine at 195 Post Road, Darien.

Frank D. Riccio, M.D. announces the opening of an office for the practice of general medicine at 2064 Barnum Avenue, Stratford.

Jacob B. Sigal, M.D. announces the opening of an office for the practice of urology and urological surgery at 219 West Main Street, Meriden.

\$20 Million in CMS Benefits

The payment of \$20 million in surgical-medical care benefits for the members of Connecticut Medical Service, the community plan for prepaid medical care, was announced on December 30, 1954 by Dr. William H. Horton, CMS executive director.

In the brief span of five years, since it was established by the Connecticut State Medical Society, CMS, largely through its 2,353 Participating Physicians, has provided surgical-medical-maternity care coverage payments for more than 390,000 persons. Especially significant is the fact that for over 200,000 of these CMS paid full charges of the attending physicians because the member-patients were entitled to Service Benefits, the unique and exclusive feature of CMS.

Today the membership of CMS, the Blue Shield plan for Connecticut, is at an all time high of more than 860,000 persons, with many of them enrolled through 7,000 business firms throughout the State. CMS currently processes and pays 11,200 claims every month with an average disbursement of \$567,400, representing the payment of \$26,700 every working day.

CMS members in New Haven County received the largest share of benefits, with payments for them totaling \$7,300,000. Hartford County members received the second largest share, with their payments totaling \$6,200,000. Fairfield County members received \$3,060,000; Litchfield County, \$1,150,000; New London County, \$1,140,000; Middlesex County, \$700,000; Windham County, \$350,000, and Tolland County, \$90,000. The distribution of these payments is due to the fact that the greater part of CMS membership is in the industrial areas of the State.

American Society for Artificial Internal Organs

The latest in organizations includes investigators and clinicians prominent in the development of artificial kidney, artificial heart-lung machines, and similar biochemical equipment. They call themselves the American Society of Artificial Internal Organs and they will hold their first meeting in Atlantic City in June just prior to the AMA sessions.

More Beds — More Service

Connecticut hospitals increased their capacity for community service by 222 beds during the period ended September 30, 1954 over the same twelve months in 1953. They then proceeded to make maximum utilization of this additional bed complement by giving nearly 60,000 additional patient days of service to over 8,000 short stay patients. This is equivalent to caring for a whole town of the size of New Canaan, Plainfield, or Trumbull.

The figures below provide background for these observations and disclose that increases in patient service have been substantial since 1951, the only downward trend being noted in the length of time patients must stay in the hospital during each hospitalization.

TWELVE MONTHS ENDED				
SEPTEMBER 30	1951	1952	1953	1954
Patient days (excluding newborn)	1,880,673	1,930,999	1,938,332	1,997,882
Percentage change	100.0%	102.7%	103.1%	106.2%
Patients cared for	230,851	243,907	254,388	262,627
Percentage change	100.0%	105.7%	110.2%	113.8%
Average length of stay	8.1 days	7.9 days	7.6 days	7.6 days

Another Antibiotic

Discovery of a new antibiotic, primycin, has been announced by T. Valyi-Nagy, J. Pri, and I. Szilagyi of the University of Debrecen, Hungary, in the December 11 issue of *Nature*. The material is made by microorganisms found in the larvae of the wax moth, *Galleria melonella*. Primycin seems to be active against viruses, as well as against such larger organisms as the staphylococci that cause boils. Although good results in treating superficial infections in man are reported, the new antibiotic may have limited usefulness, for trials on animals showed it to be toxic.

Gaylord Farm

Across the editor's desk has come a very attractive, illustrated booklet describing Gaylord Farm Sanatorium, its physical lay-out and an outline of the care provided. Included also is a list of the Board of Directors, the names of the Medical Advisory Committee and of the staff.

FROM OUR EXCHANGES

Rechtman and Yarrow consider osteoporosis to be a rather common disorder of protein metabolism in older individuals (*Amer. Pract.*, 5:9). Treatment is relatively satisfactory if the older individual can be taught to maintain an adequate (protein) and balanced diet. Slight and undue annoyances in the area of the hip or spine should be reported at once. The doctor should be alerted to detect fatigue fractures of the spine and of the hip, so that treatment can be started before complete solution of the continuity of the bone obtains. Prevention is of primary importance.

* * * *

"Diagnoses Are Made by Physicians" is the title of an editorial appearing in the February, 1954 *North-west Medicine* (53:2, p. 124). Wonder-drug cures and machine-made diagnoses in these fast moving days have tended to obscure the importance of diagnosis. Too often screening test reports are accepted as a diagnosis. In chest diseases such an acceptance may be disastrous. The time lost may not only constitute an economic disaster but also a neglected opportunity that may lead to a tragedy.

Acceptance of a screening diagnosis by public health officials is hard to understand. Acceptance of such a diagnosis by a physician in private practice is little less than dereliction of duty. The important principle is that any report from any screening method must never be mistaken as a diagnosis. "Diagnoses are not made by machines. They are made by physicians."

* * * *

Connecticut physicians interested in State medical history will read with interest the story of The Harvey Hospital established at Madison, Wisconsin in 1862 (Middleton, *Wis. Med. Jour.* 53:4 and 5). Gov. Louis P. Harvey was born in East Haddam, Connecticut. He migrated to the middle west in 1828. His life seems to have been an adventuresome one. In time he became the governor of the State of Wisconsin. His interest to the medical profession hinges around the fight that he and his wife made to remove the Army and convalescent hospitals of the Civil War away from the area of active campaigning. Governor Harvey's tragic death in 1862 left

the matter in the hands of his wife who won the soldier's tribute, "The Wisconsin Angel." The problem was carried to an unsympathetic Lincoln who, after hearing her plea wrote to Secretary Stanton: "Admit Mrs. Harvey at once. Listen to what she says. She is a lady of intelligence and talks sense." Mr. Lincoln seems to have passed in the course of the interview from irritability to personal resentment to depression. On the following day Lincoln issued orders that granted a hospital for wounded and sick soldiers located in the State of Wisconsin.

It is interesting to discover that a son of Connecticut had so important a part in changing the established policies of the care of the sick and wounded soldiers of the Nation.

* * * *

According to Kearns, abdominal aortography and presacral pneumography were helpful aids in diagnosis in 45 selected patients. No harmful effects attended the procedures. The author states in a further note that the series has been increased to 100 cases. ("Aortography and Pneumography," *Wis. Med. Jour.*, 53:2, pp. 139-141.) According to Kearns the value of aortography lies in the fact that it reveals significant changes in the arterial pattern. It answers a number of questions that the pyelographic outline does not answer.

Dr. Kearns makes these procedures sound simple, safe and informative. They probably are when performed with skill and with wisdom of selection. They are not, however, an office practice and not even an hospital practice, except in the hands of experience. He does admit that "several mishaps and failures occurred to impress upon us the importance of certain points in technic."

* * * *

"The Etiology of Lung Cancer; Present Status" as presented by Levin (*N. Y. State Jour. Med.*, 54:6, pp. 769-777) can be briefly summarized as follows:

(1) There are probably multiple etiologic factors, including occupational hazards and cigarette smoking;

(2) Known occupational hazards account for a relatively small proportion of lung cancer cases;

(3) The risk of lung cancer attributable to cigarette smoking is apparently several times that among nonsmokers;

(4) The evidence for excess risk of lung cancer among smokers persists when comparison is made between lung cancer patients and those with other conditions affecting the lung and bronchi and when the influence of residence and of occupation is equalized in lung cancer and in the control group;

(5) The evidence is sufficient to justify public health action in the direction of case finding and public health education to the effect that cigarette smoking must be presumed to play an important role in the production of lung cancer;

(6) Intensive further research is urgently indicated;

(7) In less than a decade the chance of developing lung cancer at some time during life has more than doubled among males in New York. Two per cent of all males may be expected to develop lung cancer at the present rate of incidence.

* * * *

Stephens and Hendrickson are of the opinion that electrolyte therapy should not be reserved for only severe cases of diarrhea ("Mild Diarrhea in Children," *Missouri Med.*, 51:2, pp. 105-106). The oral administration of an electrolyte solution in their experience corrects the imbalance resulting from the diarrhea in mild cases within twenty-four hours. An electrolyte solution with a nonabsorbable sulfonamide is effective in controlling mild diarrhea in infants and children in 89 per cent of the cases. The authors urge further and continuing investigation of this type of therapy.

* * * *

"The Electroencephalogram in Epilepsy" is based on a study of the findings in 430 cases occurring in the practice of Newman (*Cal. Med.*, 80:2, pp. 59-61). In 122 of the series the seizures were symptomatic, in the remaining, idiopathic, and the overall incidence of electroencephalographic abnormalities was little different in the two groups. In the whole group 64.9 per cent showed abnormal tracings, while in those under 16 years of age the incidence was 71.8 per cent. The highest incidence was in those patients in whom seizures had begun when they were between the ages of 10 and 15 years and in those with a duration of seizures from five to ten years. Clinical petit mal cases produced 76 per cent of abnormal

records, but only 34.6 per cent showed petit mal complexes.

It is obvious that the electroencephalogram can provide useful information in many cases of convulsive disorders, but the presence of a normal record by no means excludes the diagnosis.

* * * *

"The Adrenogenital Syndrome" is the subject of an extensive discussion by Schwartz (*G. P.*, IX:2, pp. 71-79). The author concludes that the adrenogenital syndrome is an uncommon disorder, characterized by masculinization in the female and precocious isosexual development in the male. It is the result of adrenal hyperplasia or tumor, the former responding to cortisone therapy and the latter to surgical removal. Schwartz emphasizes the importance of prompt recognition and treatment of concomitant adrenal insufficiency of the "salt-losing" type.

* * * *

"The Modern Concept of Otitis Media" is an almost forgotten subject (Hickey, *Jour. Kan. Med. Soc.*, LV:2, pp. 63-66). The discussion of otitis media as it presents itself in every day practice is discussed in detail. The modern treatment of acute otitis media with antibiotics is accompanied by certain pitfalls, among which may be mentioned chronicity and the development and progression of mastoid infection to almost complete breakdown without alarming symptoms. Myringotomy in the author's opinion is still a proper procedure and is to be preferred to spontaneous rupture of the tympanic membrane (myringotomy in every acute otitis media case is not advocated). In the modern surgical management of chronic otitic suppuration the direct approach by endaural mastoidectomy is advocated as offering greater safety and shorter patient convalescence.

* * * *

Douglass suspects that cesarean section is now "frequently used as a replacement for good obstetrical judgment and instead of skillful, yet safe deliveries from below." ("Indications for Cesarean Section," *Jour. Tenn. State Med. Assoc.*, 47:1, pp. 11-17.) Judiciously used cesarean section is an important weapon in the reduction of infant and maternal mortality. Among the indications cited are (1) previous uterine incision, (2) disproportion and inertia, (3) bleeding, (4) abnormal fetal position, (5) toxemia and (6) other conditions such as block-

ing tumor, double uterus, carcinoma of cervix and many special situations. The fact is pointed out that maternal and fetal mortality are both increased in the uncomplicated cesarean section compared with the uncomplicated vaginal delivery.

* * * *

“The Improved Prognosis for Tuberculous Meningitis” is the subject of a discussion by Lebovitz appearing in the January issue of the *Pennsylvania Medical Journal* (57:I, pp. 29-32). The author points out that prior to the streptomycin era this disease was invariably fatal. The accuracy of this statement may be questioned but the fact remains that Lebovitz reporting on four cases has three probable cures.

The diagnosis should be made at the earliest possible moment and treatment should be instituted at once. The author’s choice is intrathecal streptomycin therapy together with streptomycin intramuscularly and PAS (paraaminosalycilic acid) and IHN (isonicotinic acid hydrazide) orally. Therapy intrathecally should be continued for at least eight to twelve weeks following the last normal spinal fluid culture, and intramuscular and oral therapy continued for eight months to one year.

The amount of streptomycin given intrathecally varied somewhat but seems to have averaged about two grams per day. PAS about nine grams and IHN 400 milligrams were given orally each day. Later in the treatment the doses were decreased somewhat and the spacing was widened. Streptomycin had to be stopped once after four weeks because of its toxicity. There were remarkably few complications in the small series of cases presented.

* * * *

Sears of Yale University has this to say in a discussion of human ecology (*Science*, 120:3128, page 960): “Any study that concentrates only on what is wrong—whether it be bodily disease or social pathology—while neglecting the normal and healthy must fail. The ancients knew a great deal about disease but did not understand health. Modern medicine began when attention was turned to the structure and functions of the normal human body. I sometimes fear that much social science is still preoccupied, as ancient medicine was, with pathology. Too many students seem to feel that sociology is a matter of counting privies or crusading against abuses in our society.”

In Russia, (*Science* 120:3126) Rakov reports that gastric cancer is the most common type in men and

women and accounts for 32 per cent of all cancers. About 60 per cent of the gastric patients are admitted to hospitals. The radical surgery required can be carried out in only about half of these patients. Most surgeons operate for gastric cancer with only a local anesthetic. Usually a subtotal or total gastrectomy is done. Partial resection is considered only palliative. The postoperative mortality for total gastrectomies is 15 to 16 per cent. The five year survival rate is about 50 per cent in the absence of metastases and 23 per cent with metastases. Approximately 10 per cent of all gastric cancer patients who report to a physician can be cured.

* * * *

At the Sixth International Cancer Research Congress held in Brazil in 1954, McWhirter of Edinburgh, Scotland cited his results on 2,200 cases of breast cancer treated between 1941 and 1948 by simple mastectomy and (starting ten days after surgery) with a course of roentgen rays daily for three weeks. (*Bulletin of Cancer Progress*, 4:6, Nov. 1954.) The results compare favorably with the best achieved by radical mastectomy and give the patients a minimum of distress. Five year survivals (counting every death, regardless of cause) in the operable group amount to 60 per cent and in the inoperable group, 32 per cent. Ten year survivals among the operable patients (excluding all older than 70 years) are 48 per cent. Sixteen per cent of the inoperable cases were alive ten years after surgery. Advantages of this treatment, as McWhirter sees them, are: high survival rate, reduction in surgery and consequent capacity for bigger roentgen-ray doses, avoidance of edema, less mutilation, and less shock. A few patients, pregnant or lactating at the time of treatment, have survived considerable periods—none in an earlier series lived long after radical mastectomy or radical mastectomy and radiation. In recent years, McWhirter has been delivering higher doses to the internal mammary node area (requiring a cautious multiportal approach to avoid lung injury), and normal doses to substernal, supraclavicular, and axillary regions, and this seems to be giving better results. He feels that super-voltage therapy may provide even greater benefits and will try that instead of current conventional radiation. Most survivals are in the 40 to 50 and 55 to 65 year age group and poorest results in those more than 65. He urged the establishment of standards of results for comparative purposes and a routine audit of books to ascertain exact results of surgeons and investigators in this field.

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Recording Secretary, Mrs. Charles Culotta, Hamden

Corresponding Secretary, Mrs. C. Murray Gratz, Cos Cob

Treasurer, Mrs. Joseph Woodward, New London

Reading of interest to doctors' wives during December was listed in the AMA PR "This Month in Magazines" as follows: "Changing Times," *Kiplinger Magazine*; "Better Hospital Care for you Now," *Redbook*; "This PTA built a \$700,000 Clinic," *McCall's*; "Pills that Chase Away the Blues," *Pageant*; "The New TB Drugs," *Reader's Digest*; "Do You Know What's Good for You," *Woman's Home Companion*; "I Was Sure I Was Sterile," *Cosmopolitan*; "What is Hypnotism?" and "New Hope for the Deaf," *Coronet*; "A New Doctor Moves In," *Life*, November 29; "Cold Can Save Your Life," *Saturday Evening Post*, December 4; "Are you Bitter-Sweet or Bitter-Bitter?", and "Schizophrenia," *Collier's*, December 10; "Exercise Can Help your Heart," *Look*, December 14; "Community War Cry," *Family Weekly Magazine*, December 26; "How to Sleep Soundly," *Family Weekly Magazine*, December 26.

County News

HARTFORD

To save writing and telephone calls, Hartford has sent its members a mimeographed sheet listing 20 committees headed by the statement: Please Check Your Preference. Obviously, there can't be many members who, faced with this wide choice, would have the temerity to admit no interest in any of them. Work for the rummage sale was handled similarly, this time with the departments listed: plants, food, checking and packing, etc. This sheet is part of the News Letter which includes a welcome to and a listing of new members.

LITCHFIELD

The Christmas Evening Party held in early December was a buffet served at the Conley Inn, Torrington. White gifts and contributions were collected to be sent the Fairfield State Hospital. This county has selected the AMA broadcasts entitled "The Best is Yet to Be," for transmission over WLCK for 13 Sundays starting January 2.

MIDDLESEX

The Public Relations Committee has arranged for a series of AMA radio transcriptions: "Chats with the Champs," to be heard over WCNX, Middletown, for 13 consecutive Saturdays beginning January 1.

NEW HAVEN

The January 24 meeting featured a program by the Civilian Defense chairman, Mrs. James Van Leuvan, and Mrs. Eleanor Finch of Clinton, who discussed and demonstrated methods of making hand-blocked wrapping paper and cards.

Plans are being formulated for the annual dinner-dance of the Medical Society and the Auxiliary. It will be held on March 24 at the Waverly Inn, Cheshire.

NEW LONDON

There was a Membership Tea held in December at the home of Mrs. Sidney Drobnes. The 50 members present were treated to several readings pertaining to doctors' wives and their auxiliary given by Mrs. Harold Higgins. There was a display of art which included paintings, jewelry, ceramics and needlepoint. Members brought gifts for the Norwich State Hospital Christmas program.

There will be a semi-formal dance February 16 at Lighthouse Inn. Proceeds from the affair will go to the AMEF.

Frozen Semen Bank

R. G. Bunge, W. C. Keettel, and J. K. Sherman of the State University of Iowa have established a frozen human semen bank, probably the first of its kind. They let its existence be known in a recent report on the semen freezing and storing method published in the journal of the American Society for the Study of Sterility. Three normal babies have already been born, and a fourth is almost ready to be born, fathered by human semen frozen and stored in the bank.

SPECIAL NOTICES

CONNECTICUT VETERANS ADMINISTRATION MEDICAL SOCIETY

February 3

Review of Diabetic Outpatient Program
Robert R. Levin, M.D.

February 10

Psychotherapy
Isidore Schnap, M.D.

February 17

Clinicopathological Conference
Einar A. Lundberg, M.D., moderator

February 20-22

Visit to Lederle Laboratories

February 24

Panmyelosis: A case presentation
Robert J. Molloy, M.D.

Meetings are held at 8:30 A. M. at the Veterans Administration Regional Office, 95 Pearl Street, Hartford, Connecticut, in the Main Conference Room. All interested physicians are cordially invited to attend.

The Hartford Heart Association in cooperation with the Hartford Hospital presents A SYMPOSIUM ON THE MANAGEMENT OF CORONARY ARTERY DISEASE

SPEAKERS

Joseph B. Vander Veer, M.D., assistant professor of Clinical Medicine, University of Pennsylvania School of Medicine

The Management of Patients Severely Ill With Acute Myocardial Infarction

Samuel A. Thompson, M.D., F.A.C.S., assistant professor of surgery, New York Medical College

The Surgical Treatment of Coronary Artery Disease and Myocardial Ischemias

Moderator: John C. Leonard, M.D., director of Medical Education, Hartford Hospital

Time: 11:00 A. M.-1:00 P. M.

Date: Thursday, February 17, 1955.

Place: Amphitheater, Hartford Hospital, 80 Seymour Street.

YALE UNIVERSITY SCHOOL OF MEDICINE E.N.T. SCHEDULE — 1955

February 2. Case presentations

February 7. Anatomy demonstration, Eustachian tube, sphenopalatine ganglion.

February 9. E.N.T.-Pathology Conference.

February 14. Anatomy demonstration, floor of mouth and tonsil.

February 16. Nasal surgery, case presentations.

February 21. Anatomy demonstration, larynx.

February 23. E.N.T.-Radiology Conference.

March 2. Case presentations.

March 9. Film, Endaural Mastoidectomy.

E.N.T. Surgical Pathology Conferences held in large autopsy room, Brady Building.

E.N.T.-Radiology Conferences held in Radiology classroom, second floor, Clinic Building.

Chest Conferences—Fitkin Amphitheatre.

Wednesday afternoon meetings in E.N.T. clinic waiting room, fourth floor, Clinic Building.

Anatomy demonstrations—Prosector room, third floor, Sterling Hall of Medicine.

EIGHTH CONNECTICUT POSTGRADUATE SEMINAR IN PSYCHIATRY AND NEUROLOGY BASIC PSYCHIATRY At Seminar Lecture Hall Connecticut State Hospital, Middletown

February 7

3:00-5:00 P. M. Psychological Testing of Intellectual Development and in Organic States

Dr. Samuel B. Kutash

5:00-7:00 P. M. Affective Disorders

Dr. Francis J. Braceland

8:00-10:00 P. M. Hypnotherapy

Dr. Lewis R. Wolberg

February 14

3:00-5:00 P. M. Projective Techniques

Dr. Roy Schafer

5:00-7:00 P. M. Organic States, Acute and Chronic

Dr. Paul H. Hoch

8:00-10:00 P. M. Individual Psychotherapy of the Psychoses

Dr. Elvin V. Semrad

February 21

3:00-5:00 P. M. Culture and Mental Illness

Dr. Joseph M. Lubart

5:00-7:00 P. M. Senescence and its Reactions

Dr. Maurice E. Linden

8:00-10:00 P. M. Psychotherapy With Schizophrenics

Dr. Frieda Fromm-Reichmann

February 28

3:00-5:00 P. M. Psychosomatic Approach in Medicine

Dr. Sydney G. Margolin

5:00-7:00 P. M. Psychiatry and Law

Dr. Winfred Overholser

8:00-10:00 P. M. Psychosomatic Disorders

Dr. Theodore Lidz

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TWENTY-FIRST ANNUAL CONFERENCE TALKS — 1955 SERIES

Ives Hall of the Institute of Living

This series is designed to offer a comprehensive survey of developments in psychiatry and related fields of medicine, and more specifically to stimulate discussion and to provoke the exchange of ideas regarding techniques of research and general therapeutics.

Wednesday, February 9

Florence B. Powdermaker, M.D., formerly chief psychiatrist, Educational Section of the Division of Psychiatry, Veterans Administration; associate psychiatrist, College of Physicians and Surgeons, Columbia University
Schizophrenia

Wednesday, February 16

Howard P. Rome, M.D., head of the Section of Psychiatry, Mayo Clinic; professor of psychiatry, The Graduate School, University of Minnesota
The Concept of the Body Image

Wednesday, March 16

Winfred Overholser, M.D., superintendent, St. Elizabeths Hospital; professor of psychiatry, George Washington University School of Medicine, Washington, D. C.
The Psychiatrist and the Law

Wednesday, March 30

Lawrence C. Kolb, M.D., director of the New York State Psychiatric Institute; Professor of Psychiatry, Columbia University
The Psychophysiology of Pain

Conference talks begin at 8:00 P. M. and are open to members of the medical profession.

AMA MEETING OF STATE COMMITTEES HANDLING RURAL HEALTH PROGRAMS

East Room, Fifth Floor, Schroeder Hotel
Milwaukee Wisconsin, February 24, 1955

F. S. Crockett, M.D., presiding

8:00 A. M. Registration—4th floor

10:00 A. M. Greetings

Gunnar Gundersen, M.D., member Board of Trustees, American Medical Association, La Crosse, Wisconsin

10:10 A. M. Purpose of meeting

F. S. Crockett, M.D., chairman, Council on Rural Health, American Medical Association, Lafayette, Indiana

10:15 A. M. Preparation for Country Practice

Moderator: Fred A. Humphrey, M.D., regional director, Council on Rural Health, Fort Collins, Colorado

10:20 A. M. The Human Factors

A. P. Peake, M.D., Volga, South Dakota

10:35 A. M. Preceptorships

Conrad Barnes, M.D., Seneca, Kansas

10:50 A. M. Senior Medical Day Programs

Charles Ashby, M.D., Geneva, Nebraska

11:05 A. M. Lecture Series on Practice in a Rural Community

E. K. Yantes, M.D., Wilmington, Ohio

11:20 A. M. Discussion

12:15 P. M. Adjournment

AMERICAN COLLEGE OF SURGEONS SECTIONAL MEETING

Providence, Rhode Island, March 3-5
The Sheraton-Biltmore

Henri E. Gauthier, Chairman

This two and one-half day concentrated scientific program will offer, in addition to numerous surgical motion pictures, these presentations.

PAPERS

The Acute Gallbladder

Orland F. Smith, Providence

Guiding the Daily Care of the Sick Surgical Patient

Francis D. Moore, Boston

The Clinical Role of Plasma Volume Expanders

Jonathan E. Rhoads, Philadelphia

Congenital Anomalies of the Urogenital Tract

William J. Engel, Cleveland

Esophageal Hiatus Hernia

J. Murray Beardsley, Providence

Anorectal Surgery

Garnet W. Ault, Washington

Indications for Sphincterotomy

Henry Doubilet, New York

Some Personal Experiences in the Treatment of Abdominal Aneurysm

Robert R. Baldrige, Providence

Fractures of the Epiphyses

Alexander P. Aiken, Brookline

Use of Mechanical Heart-Lung in Cardiac Surgery

John H. Gibson, Jr., Philadelphia

Laryngeal Paresis and Paralysis

Harold E. Harris, Cleveland

Diagnostic Problems in the Chest

Julian Johnson, Philadelphia

Surgical Diseases of the Spleen

Robert M. Zollinger, Columbus

The Gastric Ulcer Problem

I. S. Ravdin, Philadelphia

Special Problems in Pancreatic Surgery

Richard B. Cattell, Boston

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SYMPOSIUMS

TRAUMA

Richard Warren, Brookline
J. Edward Flynn, Boston
John W. Strieder, Brookline

CANCER

John H. Garlock, New York
William J. Engel, Cleveland
Danely P. Slaughter, Chicago

PEDIATRIC SURGERY

C. Everett Koop, Philadelphia
Orvard Swenson, Boston
Jose M. Ferrer, Jr., New York

PANEL DISCUSSIONS

ACUTE RENAL FAILURE

Moderator: Francis D. Moore, Boston
Collaborators:
Jacob Fine, Boston
Ernest K. Landsteiner, Providence
John Merrill, Boston

BILIARY TRACT SURGERY

Moderator: I. S. Ravdin, Philadelphia
Collaborators:
Richard B. Cattell, Boston
Henry Doubilet, New York
Robert M. Zollinger, Columbus

Academy of General Practice to Grant Postgraduate Credit for Physicians' Cancer Conference

Physicians who are members of the American Academy of General Practice will receive postgraduate credit for attendance at the 1955 State Cancer Conference for Physicians. The meeting will take place at the Hotel Taft, New Haven, March 23.

This marks the first year that this form of professional recognition has been designated for the annual cancer session. The basis for the decision by the Connecticut chapter of the Academy is the high teaching value established by the Conference and the large attendance by physicians during the seven years it has been held. The credit arrangement was announced by Peter J. Scafarello, Hartford, secretary of the Connecticut chapter of the Academy following an inquiry by the Committee planning the Conference.

The Conference is sponsored annually by the Connecticut State Medical Society, the Connecticut

Division of the American Cancer Society, Connecticut State Department of Health, and the Association of Connecticut Tumor Clinics.

Physicians members of the planning committee for the Conference comprise Bliss Clark, New Britain, chairman; Mark Hayes, New Haven; William Leahy, Hartford; Frederick Finn, Greenwich; Charles H. Peckham, Manchester.

The committee has announced that the Conference will emphasize new information on cancer diagnosis and treatment which should prove of special value to physicians in general practice. It is anticipated that the complete program will be announced in February.

AMERICAN TRUDEAU SOCIETY

Announces a Postgraduate Course "The Measurement of Pulmonary Function in Health and Disease"

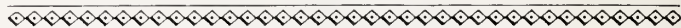
Boston, March 21-25, 1955, 9:00 A. M. to 5:00 P. M.

Sponsored by the Medical Schools of Harvard University, Tufts College, and Boston University.

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OUR NEIGHBORS



Maine

John R. Lincoln, director of anesthesia at Maine General Hospital, Portland, has been elected an associate member of the Board of Governors of the American College of Anesthesiologists for the Second District, which includes Maine, New Hampshire and Vermont. Dr. Lincoln served as resident in anesthesiology at the Hartford Hospital from 1944 to 1946.

Massachusetts

George P. Berry, dean of the faculty of medicine of the Harvard Medical School, recently announced the establishment of a new professorship to be

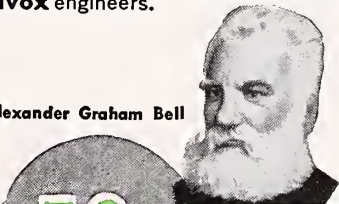


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known as the Samuel A. Levine professorship of medicine. The endowment has been provided by Charles E. Merrill, New York investment banker, who made an initial gift of \$400,000 and asked that the professorship be named for Levine, who is clinical professor of medicine at Harvard and a member of the staff of Peter Bent Brigham Hospital as well as other medical institutions. In making the announcement, Berry said that the Levine professorship "would be devoted for the foreseeable future to the study and treatment of heart conditions and cardiovascular diseases."

Harvard University has begun a joint five-year, \$500,000 research program with the Arabian American Oil Company. This program has been formulated to aid in the attack on trachoma and other eye diseases prevalent in Arabia. The oil company will make available the facilities of its new medical center in Dhahran, Saudi Arabia, including three modern laboratories, and Harvard will provide the professional and technical staff for the scientific work.

Vermont

James P. Hammond, secretary of the Vermont State Medical Society and lone delegate from that organization to the AMA House of Delegates, has been elected secretary of "Aces and Deuces," an organization comprising representatives of constituent societies which have only one or two delegates serving in the House.

NEWS

from County Associations

Fairfield

Greenwich Hospital has decided to complete its fourth floor. It is making a community-wide appeal for \$300,000 with which to complete unfinished parts of the hospital. This sum when added to funds on hand will complete the fourth floor, finish two major operating rooms, enlarge the recovery room, pay for the fourth elevator, and provide additional working capital.

Franklin S. DuBois of The Silver Hill Foundation, New Canaan is the author of "The Sense of Time and Its Relation to Psychiatric Illness" published in the *American Journal of Psychiatry*, July, 1954; also

of "Perspective in Psychiatry" published in the same journal, October, 1954.

Hartford

Matthew H. Griswold, chief of the State Health Department's division of cancer and other chronic diseases, was recently elected an honorary trustee of the American Cancer Society, Connecticut Division.

J. Edward Canby of West Hartford, medical director of the Pratt & Whitney and Chandler-Evans Division, Niles-Bement-Pond Company, died at the Hartford Hospital on January 2. Dr. Canby was prominent in industrial medical circles.

Paul S. Phelps of Collinsville is the new president of the Connecticut Trudeau Society. R. C. Edson of West Hartford will serve the Society as secretary-treasurer and William J. Lahey, director of education at St. Francis Hospital, Hartford, is a new member of the Executive Board.

Benjamin L. Salvin was elected chief of staff at the annual meeting of Mt. Sinai Hospital, Hartford.

At the annual meeting of the Hartford Medical Society last month Louis P. Hastings was elected president; Samuel Donner, president-elect; Lewis P. James, treasurer; Charles E. Jacobson, Jr., secretary; and Ernest Caulfield, librarian. The new trustees are Thomas J. Luby, Douglas J. Roberts and Thacher W. Worthen. James R. Miller was elected to the House Committee.

John Donnelly, clinical director of the Institute of Living, has been appointed executive officer of the hospital by the Board of Directors.

Francis J. Braceland, psychiatrist in chief at the Institute of Living, addressed the annual meeting of the Travelers Aid Society of Hartford last month.

Harry L. F. Locke of Hartford has been appointed to the Commission on the Care and Treatment of Chronically Ill, Aged and Infirm to replace John C. Leonard, resigned.

Once again HCMA participated in the Hartford Times Travel Show in January. The motif of the exhibit explained what health precautions the traveler can take when he goes abroad. Last year over 13,000 persons saw this exhibit at the West Hartford Armory. This year the show was held at the auditorium on 555 Asylum Street.

The Hartford Dental Society has asked HCMA to participate in their Children's Dental Health Week in February. The purpose of this educational week

is to emphasize to the parents the relationship between the mouth and the rest of the human body.

The new working manual on medical public relations prepared for county medical societies by the Department of Public Relations of the AMA lists HCMA activities on our emergency telephone service, the *Bulletin*, and our "Guide To Membership" which is distributed to all incoming members.

Frank J. Leo returned last month after a sojourn in the army as Chief of Obstetrics and Gynecology at Camp Pickett, Virginia. He has now opened his office at 28 Terry Road, East Hartford.

Recently returning from an extended European trip, Charles W. Goff lectured in Germany, Egypt, Greece and Lebanon. He also attended the International Congress of Orthopaedic Surgeons in Bern, and the Polio Conference and the World Medical Association meeting in Rome.

Charles I. Solomon spoke last month before the New London County Medical Association on "Psychiatric Problems in the General Hospital."


William B. Scoville recently attended the Congress of Surgery in Mexico City where he delivered a paper on "The newer techniques in neurosurgical operations as developed by the department of neurosurgery at Hartford Hospital."

John J. Blasko spoke to the Civitan Club on the importance of remembering patients in mental hospitals during the holiday season.

Edward P. White has been named president of the Hartford branch of the American Cancer Society.

Maurice T. Root has been elected president of the medical-surgical staff at Hartford Hospital. Other officers named were: Arthur Unsworth, vice-president; Louis Middlebrook, secretary; and Philip G. McLellan, chairman of the executive committee.


The annual meeting of the Advisory Committee of the State Journal Advertising Bureau held in Miami was the last session at which Stanley B. Weld presided as chairman. Because of his years of service in behalf of the State Journal group, the members of the Advisory Committee, by unanimous vote, passed a Resolution of Commendation for Dr. Weld. His present term of office which expired on December 31, 1954 brought to a close a twelve year period as a member of the Advisory Committee. For the past ten years Dr. Weld has been chairman of this Committee. In his post as editor in chief of the CONNECTICUT STATE MEDICAL JOURNAL he will continue his support of the Bureau program.



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New Haven

Frederick A. Wies of New Haven gave a paper entitled "Surgical Treatment of Senile Entropion" before the 1954 autumn meeting of the American Academy of Ophthalmology and Otolaryngology in New York City.

Patrick J. Brennan retired as chief of staff of St. Mary's Hospital, Waterbury in December, 1954. Dr. Brennan has been a member of St. Mary's medical staff since the hospital opened in 1909 and has been chief of staff since 1948. He is succeeded by Andrew J. Jackson.

William Mansfield Groton has been appointed to the active staff of the Griffin Hospital in Derby as an assistant attending in the Department of Medicine. Dr. Groton is a native of Westerly, Rhode Island, and received his Doctor of Medicine degree from the University of Pennsylvania in 1947. He served a two year internship from 1947 to 1949 at the Pennsylvania Hospital and a two year residency

in medicine at the Rhode Island Hospital in Providence. Dr. Groton also has served in the United States Navy for two and one-half years. Before his appointment to the Griffin Hospital, he served as a staff physician at the Laurel Heights Sanatorium, Shelton, Connecticut.

J. Nicholas D'Esopo of New Haven was recently elected vice-president of the Connecticut Trudeau Society. New members of the Executive Board are Sterling B. Brinkley of Wallingford and Alfred Hurwitz of West Haven.

Vernon W. Lippard, dean of Yale University School of Medicine, has been elected president of the Association of American Medical Colleges.

On December 21, 1954 at the assembly room of the Memorial Unit of the Grace-New Haven Community Hospital, E. Cuyler Hammond gave an interesting talk on "The Chronic Effects of Smoking."

On January 5, 1955 Arthur Allen, chief, Surgical Service, Massachusetts General Hospital, addressed the New Haven Medical Association Meeting.

Charles J. Foote of New Haven, second ranking member of the group of physicians who have completed more than 50 years of membership in the State Society, died on December 29, 1954 at the age of 93 years.

Arthur Allen, chief, Surgical Service, Massachusetts General Hospital, gave a very instructive lecture on surgery of the colon at the New Haven Medical Society on January 5. On January 19 Alan Bateman, Silliman professor of geology, spoke on India.

On February 2 James Winfield, professor of surgery at the Flower Hospital, New York, will be the speaker at the New Haven Medical Society.

New London

The regular monthly meeting of the staff of the William W. Backus Hospital in Norwich was held on December 9, 1954 in the clinic building. The speaker for the evening program was Attorney Cyril Coleman of Hartford, who spoke on "Malpractice" as of interest to the physician.

At the recent meeting in Atlantic City of the College of Surgeons, Paul Gerity, M.D. of New London presented an original paper on the effects of ACTH and Cortisone on the gastric mucosa. His work was done under the auspices of the Department of Surgery at the Yale Medical School. The

studies on the gastric mucosa were done through the gastric pouches of dogs.

James Sturtevant of New London has recently been sporting a new tan which he acquired on a three weeks vacation in South America and British Guiana.

Alfred Labensky also recently returned after a month's vacation during which time he attended several medical conventions and visited with his daughter in Washington.

Charles F. Dyer has been appointed to the Surgical Staff of the Lawrence and Memorial Hospital in New London. Alfred Labensky has been reappointed chief of staff of the Lawrence and Memorial Hospital for the coming year.

The January meeting of the New London County Medical Association was held at the Mohican Hotel on January 6. The speaker at the scientific portion of the program was Wilson F. Smith, M.D. of Hartford, who spoke on "Obesity and Diet."

NEW BOOKS IN REVIEW

AN OUTLINE OF A COMPARATIVE PATHOLOGY OF THE NEUROSES. By Ludwig Eidelberg, M.D. New York: International Universities Press, Inc. 1954. 263 pp. \$4.50.

Reviewed by JOHN DONNELLY

Intended for advanced students of psychoanalysis, this volume presents an interesting attempt at introducing a quantitative approach to psychiatric conditions. In the early portion of the book there is a review of the theory of instincts, the unconscious and defense mechanisms, treated along the lines of the author's own orientation. In the latter portion of the book the various forms of personality disorder are examined from the hypothetical viewpoint that a varying proportion of the two primary instincts, Eros and Thanatos, are present in each. Just how the "quantity" of each instinct is to be measured is not indicated but would appear to rest upon subjective clinical judgment.

The author is well aware of the possible criticisms that might be raised. In fact, he prepares for these in the concluding paragraph with the statement, "I do not want to pretend that I approve completely of what I have written." The reader would also like to know what aspects of the hypothesis are unacceptable to the author.

GENETICA MEDICA. 1^{um} Symposium Internationale. Geneticae Medicae. Edited by Luigi Gedda. Rome: Istituto Gregorio Mendel. 1954. 490 pp. 168 illustrations.

Reviewed by STANLEY B. WELD

To one who is accomplished enough as a linguist to be conversant with French, German and Italian, as well as



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English, and who is interested in the study of genetics this volume should be of considerable interest. It contains the transactions of the First International Symposium on Genetic Medicine convened in Rome at the inauguration of the Gregor Mendel Institute established for research in genetics, particularly of twins. Should the fact that the essays appear in four different languages tend to discourage the prospective reader, there are summaries furnished at the end of the majority of the papers in the other three languages.

The editor's address which appears at the beginning of the volume describes the characteristics of medical genetics, namely, of the insertion of laws and experiences elaborated during the last fifty years in the so-called corpus of modern medicine. To understand this insertion physicians should have a good knowledge of genetics. Attention is called to the fact that studies of twins show that longevity in man is influenced by specific idiosyncratic factors which determine the maximum age attainable. It is pointed out that the rise of psychiatry and human genetics have produced a new scientific discipline called psychiatric or psychological genetics.

Many diseases are discussed in order to show their relationship to heredity. These include endocrine disorders such as hyperthyroidism, myxedema, goitre, diseases of the hypophysis; pernicious anemia; papilla leporina; vitiligo; Leber's optic atrophy; discondrosteosy; disorders of the skeletal system; hemolytic disease of the newborn; polycystic kidney disease; acute anterior poliomyelitis; and Heberden's nodes. An address by Pope Pius XII is included which reveals the remarkable interest and insight of the Holy Father in the problems of genetics.

This is a handsomely bound, beautifully illustrated volume, documented as well with an abundance of charts and

tables. Unfortunately the English in the volume shows a lack of proper editing with many misspelled words, an omitted line or two, misuse of punctuation, an even one letter set upside down. No such errors appear in the essays by visiting speakers other than English.

We are indebted to the Italian editor for this volume which comes to us from Rome. We commend it to our readers.

SPORTS INJURIES PREVENTION AND ACTIVE TREATMENT. By Christopher Woodard, Honorary Consultant to British Olympic Teams 1948 and 1952. London: Max Parish. 1954. 128 pp. \$3.

Reviewed by STANLEY B. WELD

This volume is written by a prominent British physician and athlete. He represented Cambridge University in the half-mile race and now specializes in the treatment of soft-tissue injuries in athletes.

The theme of the book is active motion for all soft-tissue injuries to prevent fibrosis and adhesions, provided, of course, no fracture exists. The book is not intended for physicians but for athletic directors, trainers, etc. One might question the ability of some of these latter groups, in this country at least, to determine accurately whether or not only soft-tissue injury exists.

Dr. Woodard offers a valuable manual for the guidance of those who guard the participants in our sports. In addition to chapters on injuries, he deals with diet, staleness, and the ethics and efficacy of various forms of doping. The line plates and engravings are plentiful and should prove helpful.

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SYNCOPE

Its Differential Diagnosis

ADRIAN OSTFELD, M.D., *New York City*

SYNCOPE may be defined as an acute, reversible loss of consciousness and voluntary control. It is an important and frequent manifestation of disease. In making a specific etiologic diagnosis in a case of syncope one proceeds in the same manner utilized in diagnosing any other illness. A carefully taken history, a thorough physical examination and the intelligent use of ancillary data, i.e., x-rays, electrocardiograms, blood chemical determinations, etc., are the means by which one makes such a diagnosis. A discussion of differential diagnosis in syncope would be very dull and incomplete indeed if it consisted of a list of causes of fainting and a cataloging of points in the history, physical examination and laboratory studies appropriate to each cause. Therefore we propose to deal with this discussion in a different manner. We will present as a framework a very simple physiologic classification of syncope. On this framework we shall base a more complete discussion of the mechanisms of syncope, how these mechanisms appear to the patient and to the physician, how they effect other bodily functions and pertinent therapeutic considerations. In this way the important factors in differential diagnosis will be clarified.

VASODEPRESSOR FAINTS

In our present state of knowledge we can be no more specific than to state that syncope is caused by a derangement in functioning of the central nervous system. Inadequate oxygenation of brain tissue originates the great majority of these derangements of function and will be accorded first place in our discussion. The inadequate oxygenation may be due either to a sudden fall in blood pressure or to a sudden fall in effective cardiac output. Since there is

The Author. *Research Fellow in Medicine, Cornell Medical School; Provisional Assistant Physician, New York Hospital*

SUMMARY

Syncope is always due to transient brain dysfunction most often caused by lack of oxygen. It may be provoked by the sight of blood on a pricked finger or by a malignant glioma. It may mean incipient death or be amenable to medical, surgical or psychiatric treatment. An etiologic diagnosis is usually not difficult to make and is rewarding to patient and physician.

some variation in the terminology of syncope, we shall call those faints due to a fall in blood pressure vasodepressor faints.

Among the vasodepressor faints, the most common is the ordinary simple faint or swoon. Not now as fashionable as in the Victorian era, it is still almost a daily occurrence in every physician's office, in every laboratory where blood is drawn, in every situation where sudden bad news may be communicated. If one examines the situations in which these faints occur, one finds that they characteristically possess two attributes. First, the situation is interpreted as an overwhelming threat and secondly, as George Engel¹ points out, the threat is of such a nature that it cannot be met adequately either by fight or by flight. Its value in promoting survival in humans is uncertain.

The clinical appearance of a patient undergoing a syncopal attack is well known. Seconds to minutes before the attack the patient may show pallor, retching or vomiting, sweating, and will be aware

Presented at 29th Connecticut Clinical Congress, New Haven, September 16, 1954

that syncope is imminent. He will complain of giddiness, nausea, weakness, and suddenly collapse. If one can carefully follow pulse and blood pressure, one observes that there is bradycardia and a significant drop in blood pressure at the moment of syncope. Although the skin is pale, it is established that there is an increase in muscle blood flow² at this time. Electroencephalograms obtained during the unconscious period show high amplitude slow waves³ which disappear when consciousness returns. It is believed that the mechanism of the drop in blood pressure, and therefore of the cerebral anoxia, is an acute loss of arteriolar tone primarily in muscle. Pooling of blood in the legs aggravates the deficiency. The vasodepressor reaction may persist for hours after the stimulus has been removed and this should be taken into account by anyone in attendance.

The recumbent position usually will promote a return to consciousness in a few minutes. It eliminates the effects of gravity in pooling blood in the legs and enables a lowered blood pressure more easily to maintain cerebral circulation. There is a great deal about the mechanism of vasodepressor syncope which is not known because of the difficulty in studying it under controlled conditions.

Treatment may be divided into symptomatic and prophylactic. During the faint or immediately before, one should place the patient in a horizontal position, or, better yet, elevate the legs.⁴ Painful stimuli by causing reflex arteriolar constriction may help to shorten the period of syncope. When the patient stands up after an attack he should be told to move about to prevent pooling of blood in the legs. Prophylactically, if one can anticipate that a forthcoming situation may provoke syncope, one can assess the patient's feelings and attitudes concerning the situation and interpret it to him in such a way that it will be seen as less threatening.

In the production of simple syncope it is the upright position plus a sudden threat that cause the faint. In the other types of vasodepressor syncope, sometimes called as a group the orthostatic syncopes, it is the upright position plus other factors which cause the faint.

In all persons there is a decreased venous return in the upright position which tends to lower cardiac output. Subjects who faint on assuming the upright position exhibit an extreme fall in blood pressure with or without a fall in cardiac output.^{5,6} Studies of cardiac output which are done by the Fick

method are subject to criticism because very rapid changes are not picked up. Such studies tend to minimize the importance of pooling of blood in the leg veins. The fact is that femoral arterial occlusion abolishes orthostatic syncope.⁷ In addition to venous pooling and possible decrease in cardiac output, patients with orthostatic hypotension often have a defective mechanism for sustaining arteriolar tone. Here again during syncope the electroencephalograms show larger amplitude, slow waves, and the pulse rate is usually but not always slowed.

The diagnosis can be made simply by asking the patient to stand. It should, however, be remembered that the tendency to develop postural hypotension may vary from day to day. Cause of the variation is unknown.

Syncope may be caused by prolonged motionless standing. The fallen guardsman photographed while the queen is trooping the colors is an example. The mechanism here is reported to be pooling of blood in the legs with a failure of an unknown homeostatic mechanism which enables the blood pressure to drop precipitously at the moment of syncope. Cardiac output probably is decreased concomitantly.⁸ Large varicose veins have been shown greatly to augment pooling of blood in the legs.⁹ This may account for many complaints of giddiness or dizziness in the upright position, possibly through promoting a decrease in cardiac output. It is included, however, with the vasodepressor syncopes because the upright position is necessary to bring on the symptoms. Syncope is rare with varicosities although symptoms described above are common. Surgical ligation of veins in the cases reported caused relief. When a patient undergoes a prolonged stay in bed the reflexes that enable adaptation to the upright position are "dulled" and the first few attempts to get out of bed may be accompanied by syncope. Less commonly this syncope appears during the prodromal period of an acute infection or during a procaine reaction. Pregnancy, aging and rapid adolescent growth have been implicated without good evidence as predisposing factors.

CAROTID SINUS SYNCOPES

The carotid sinus syncopes, so well described by Soma Weiss and associates,^{10,11,12} are usually discussed as a group. Unfortunately in our classification the three types must be discussed separately. That type of carotid sinus syncope which is due to a fall in blood pressure is a vasodepressor syncope and probably has the same mechanism as the other

vasodepressor syncope. It either never or hardly ever occurs in the upright position. The importance of recognition of carotid sinus syncope lies in the fact that carotid stripping or 9th nerve section surgically makes it a curable disease. Spontaneously occurring structural disease of the autonomic nervous system is another significant cause of orthostatic hypotension. In recent years diabetic neuropathy has probably accounted for most of these cases, *tabes dorsalis* being a more important cause in an earlier era. The combined system disease of pernicious anemia and syringomyelia are more unusual causes. Lastly there is a rare illness called chronic orthostatic hypotension in which there is disease of the autonomic nervous system which is unrelated to diabetes, pernicious anemia, etc. One can distinguish this group of diseases fairly readily because there is other evidence of damage to the autonomic nervous system or of the underlying disease state. Inability to sweat which can be readily demonstrated with iodine, starch powder, and a heat source, is often present. Impotence in the male, disturbances in bowel and bladder function, and neurologic evidence of motor or sensory lesions may be noted.

Among the vasodepressor syncope there is a group which has been given the name of "primary shock." Primary shock implies a vasomotor collapse reflex by following certain sensory stimuli. The familiar syncope following a blow to the "solar plexus" or testicles is an example. Trauma to blood vessels or to the periosteum, or acute dilatation of almost any hollow viscus will produce this sort of syncope. The so-called "pleural shock" that follows needling the pleura (usually a diseased pleura) in thoracentesis or pneumothorax is an iatrogenic form of primary shock. It is difficult clearly to delineate this group of syncope from simple syncope. Certainly there must be times when the threatening aspects of the trauma or particular significance attached to the part traumatized is a more potent agent in promoting syncope than the direct tactile or painful stimulus itself.

Finally, among the orthostatic syncope, there is a wholly man-made group which occurs in the cause of treatment of other diseases. The nitritoid crises in the treatment of syphilis and the vasodilatation promoted by nitrates and nitrites used in the amelioration of angina pectoris are examples. Sympathectomy for the treatment of hypertension and the use of ganglionic blocking agents like hexame-

thonium for the same purpose effectively paralyze the vasomotor reflexes which maintain blood pressure in the upright position and cause orthostatic hypotension and syncope.

Those cases of orthostatic syncope which are chronic require treatment. Removal of the cause should be attempted whenever possible. Ligation of varicose veins or stripping of the carotid sinus may be advisable when symptoms are frequent enough to prevent normal living. For the vascular collapse that follows procaine reaction, the immediate administration of barbiturates, preferably intravenously, and the horizontal position are indicated. In most patients with orthostatic syncope, however, treatment must be aimed at maintaining adequate blood pressure in the upright position. The use of abdominal and leg binders or elastic stockings to prevent pooling of blood in the legs and abdomen combined with oral ephedrine have been advocated. The usefulness of ephedrine and abdominal binders is doubted by some although the necessity for tight leg binders is generally admitted. During an attack of vasodepressor syncope, consciousness can be restored most rapidly if the patient lies flat with legs raised.

To summarize then the first part of our discussion: The majority of faints are due to a fall in blood pressure experienced in the upright position: that is, they are vasodepressor faints. Among these the commonest cause is a vascular reaction to an acute overwhelming threat or symbol of a threat. A failure to maintain blood pressure in the upright position causes orthostatic syncope and is due to a failure of autonomic function. This failure may be permanent and due to disease or surgical destruction of the autonomic nervous system, or temporary and aided by pooling of blood in the legs, pharmacologic action of drugs or unusual sensory stimuli. Treatment of the faint itself is merely the assumption of the horizontal position. Beyond that it depends on the specific cause of the faint.

SYNCOPE DUE TO SUDDEN DECREASE IN CARDIAC OUTPUT

Another important but less frequently occurring group of syncope is caused by a sudden decrease in cardiac output. Although this group of faints is almost always reversible, occasionally syncope is followed by sudden death. Because of this threat, and because there is commonly serious heart disease in persons undergoing such attacks, these faints

possess an ominous character not shared by vaso-depressor syncope.

The sudden fall in cardiac output may be due to ventricular asystole. The name Adams-Stokes syndrome is applied to such attacks. In the normal or diseased heart, ventricular slowing or asystole may be brought about by carotid sinus stimulation which is effective through reflex vagal action. In the diseased heart, the period of asystole usually occurs either in the course of completed heart block or when there is a delay in the establishment of a ventricular pacemaker in the transition from a normal sinus rhythm to a partial or complete heart block.¹³ Stokes-Adams attacks may also occur in ventricular tachycardia or ventricular fibrillation due usually to myocardial infarction or to digitalis intoxication.

The bedside picture of persons undergoing Stokes-Adams attacks is a characteristic one. These are middle aged, or elderly people with evidence of heart disease. The onset of syncope is instantaneous and no pulses are felt during the faint. Duration of the attack is quite brief, usually less than a minute, and attacks may be quite frequent, i.e., several in an hour. Convulsions with longer attacks are not uncommon. It is important to recall that coronary or cerebral vascular accidents may follow any syncope attack in the elderly and should be suspected when there is unsatisfactory recovery.

Since the faints are of such short duration, treatment to terminate one is usually not possible. It is possible, however, to prevent many of the attacks. If they are due to reflex vagal action on carotid sinus stimulation, atropine sulfate in doses of 1 to 2 mgm. orally or parenterally is helpful. Where it can be shown by electrocardiographic evidence that the faint is due to complete ventricular standstill, epinephrine 0.3 to 0.5 cc. intramuscularly or subcutaneously for an expected attack or ephedrine 30 to 50 mgm. 3 or 4 times daily for more chronic use is helpful through increasing ventricular irritability. If the ventricular asystole is due to ventricular tachycardia or fibrillation, quinidine or procaine in appropriate dosage is used to restore normal sinus rhythm.

Syncope often occurs in the course of a supraventricular arrhythmia, commonly auricular fibrillation or tachycardia. Treatment with quinidine constitutes the only satisfactory treatment of the syncope. Since these arrhythmias may be precipitated

after strongly felt acute emotional reactions such as rage, fear, or anxiety, it is important for physician and patient to try to modify such response.

Finally, certain structural disorders of the heart are often associated with syncope on exertion. Aortic stenosis¹⁴ is the most frequent of these. Other valvular lesions have not been clearly shown to foment syncope. Medical curiosities such as auricular ball valve thrombi in mitral stenosis or primary cardiac tumors are rarely implicated. Surgical correction of these structural defects when possible is the only treatment for the syncope.

SYNCOPE DUE TO DECREASED CEREBRAL OXYGENATION

There is another group of faints due to decreased cerebral oxygenation which fits properly neither with the vasodepressor faints nor with those due to a fall in cardiac output. In this group a fall both in blood pressure and in cardiac output is present but the essential cause is a decrease in the volume of red cells or of blood circulating through the brain. Anemia, regardless of its etiology, may if severe cause syncope. Treatment must be aimed at the anemia. A decrease in the volume of circulating blood may be brought about directly through bleeding, usually from the gastrointestinal tract. Indirectly, a decrease in extracellular fluid volume following a loss of salt and water may cause a decrease in blood volume. This occurs when one sweats and takes in only water as replacement resulting in "heat exhaustion." It occurs when vomiting and/or diarrhea become severe and prolonged, and in Addison's disease. In all these faints, treatment must be directed at the underlying deficiency. Syncope on cough, a disease of portly men with protruberant abdomens, plethoric complexions, and pulmonary insufficiency is due to cerebral anoxemia and congestion caused by acute decrease in venous return. The cough and valsalva maneuver increase right arterial pressure and force this decrease in venous return.

EPILEPSY

We are left with a large and varied group of etiologic agents which have in common the fact that they do not produce syncope by promoting generalized cerebral anoxia. The most important of this group, the epilepsies, is a large and complicated subject by itself and we can only touch on it here. The entities of grand mal, petit mal and Jacksonian or focal seizures are well enough known. How-

ever, it is important to emphasize that epilepsy may involve almost any single one or combination of motor functions, may temporarily disturb almost any sensory modality, may affect the function of any organ with autonomic innervation, or paroxysmally alter mood, behavior, or state of consciousness. It is important to recall that these fits are not a disease in themselves but symptoms only. Fits may occur in almost any disease involving the nervous system from the brain stem rostrally. Many of these diseases are curable, most are controllable. Because fits may mean life-threatening disease, i.e., brain tumor or general paresis, which can be helped if treated promptly, one should try to make an etiologic diagnosis in all cases. Those fits in which no structural defects can be found by the use of gross and microscopic pathological investigation are called idiopathic epilepsy. The physiological or biochemical lesion in these fits is yet unclear and is beyond the scope of our discussion.

In making a diagnosis of epilepsy, the history is of prime importance. The nature of the attack and its periodic and repetitive character are suggestive. An abnormal wave pattern by electroencephalographic examination is present in the majority of cases. Finally, a therapeutic trial on anticonvulsant medication may help to solve the problem.

The importance of "small strokes" as a cause of gradual mental deterioration in the elderly has been emphasized by Alvarez. The same etiology, local cerebral thrombotic episodes, may cause syncope. Certainly syncopal attacks due to cerebral emboli in auricular fibrillation and bacterial endocarditis have been observed. Transient vasospasm has been invoked from time to time as a cause of syncope. Proof that this mechanism operates is lacking. I have, however, heard patients with migraine headache describe acute giddiness or faintness shortly before a headache—one of the patients experienced faintness (but not syncope) during scotomata. It is attractive to think that vasospasm may be operative here. In malignant hypertension syncope may also be due to such a mechanism.

Earlier in the discussion the cardiac slowing and vasodepressor type of carotid sinus syncope were described. However, over half the cases of carotid sinus syncope are unaccompanied by changes either in pulse or in blood pressure. This so-called "cerebral type" is not due to generalized cerebral anoxia but its exact cause is not known. Since neither pressor

agents nor atropine is helpful, carotid stripping must be employed if attacks are frequent and severe.

There is a trilogy of generalized metabolic abnormalities which may be spoken of as causing syncope, although more properly they cause convulsions. These are low blood sugar, low blood calcium ions, and low blood carbon dioxide. Low blood sugar may occur through the action of too much insulin which has been introduced through a syringe or liberated from a functioning islet cell adenoma of the pancreas. It may be present in Addison's disease, due either to primary adrenal or to pituitary disease, and may occur in severe liver disease. Most often hypoglycemia is believed to be related to improper diet high in carbohydrates, low in protein and fats. Insulin secretion "overshoots" and 2 to 5 hours after a starchy meal, hypoglycemia develops. Symptoms and signs are present due to epinephrine release at this time, and are as one might expect, giddiness, pallor, tachycardia, palpitations, nausea, and sweating. The finding of a low blood sugar during the attack usually proves the diagnosis. Frequent small feedings, high in protein and low in carbohydrates, will usually prevent attacks.

A deficiency in calcium ions results in increased irritability of the nervous system. First tetany and later frank convulsions may ensue. The cause is usually hypoparathyroidism following accidental removal of or damage to the parathyroid glands during thyroid surgery. Intravenous administration of calcium gluconate or Ca Cl_2 will promptly terminate the seizure.

Low blood carbon dioxide occurs during hyperventilation. This is almost always due to a state of disturbed emotions in which anxiety predominates. The patients overbreathe because they feel they cannot get a deep breath or are not getting enough air. The extreme anxiety of the patients and the effectiveness of reassurance by the physician make the diagnosis easy. Breathing into a paper bag or forcefully holding the breath during such an attack usually will terminate it also. One should feel obligated here not merely to inhibit attacks but to undertake an investigation of the patient's emotions, feeling states and life situations. Psychiatric referral is often necessary. Less commonly hyperventilation may appear after encephalitic brain damage or during fever. It is the alkalosis in hyperventilation that causes first numbness of the lips, hands and feet, then evidence of tetany, and finally convulsions. It should be

remembered that in this type of alkalosis, blood carbon dioxide combining power may be normal or reduced and only the presence of an alkaline urine is a chemical "tip off" to the alkalosis.

HYSTERIA AND SCHIZOPHRENIA

Finally, there are two clinically important disease states in which syncope may be mimicked. In hysteria the patient may "throw a fit" which witnesses may describe as a faint or a convulsion. If the physician witnesses it he may be puzzled also. However, a careful history, close observation of the "seizure" and an evaluation of the patient's personality should make the diagnosis in a positive manner. It should not be necessary to have a "negative physical examination" and many "negative laboratory tests" to make the diagnosis by exclusion. Such hysterical seizures are usually performed in the presence of others, are usually made as vivid and dramatic as possible by the patient. Movements are not truly clonic or tonic; there is usually much thrashing about. Attacks often follow emotionally significant events in the patient's life and are most frequently engaged in by young women or girls. Close questioning of witnesses may reveal that the patient was obviously conscious throughout the whole procedure. The seizure is in a sense a performance to gain some end for the patient.

Schizophrenic patients may engage in catatonic postures which mimic syncope. However, if a patient is so seriously mentally ill as to engage in this form of behavior he is usually so obviously psychotic that there is no trouble in diagnosis.

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ENDOCRINE ASPECTS OF INFERTILITY

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NO attempt to overcome demonstrable barriers to conception should be undertaken unless there is evidence that the complex endocrine regulation of gonadal function is proceeding normally in both husband and wife. Such barriers may be mechanical or developmental or due to growths or infection, but their attempted correction may be expected to fail as regards sterility without assurance that ova are available with reasonable regularity to a sperm population that measures up to minimum requirements. The importance of endocrine aspects of infertility is thus brought into focus as basic to regulation and optimum production of sperms and eggs. Although defects in the pituitary-gonadal axis are the chief deterrent to normal gonadal function, other glands in the endocrine galaxy by their deficiency or hyperfunction may also be incriminated.

It may be worthwhile then, after a few general remarks, to review in turn the influence of several of the endocrines on gonad physiology and to give particular emphasis to the therapeutic use of hormone preparations from adrenal, thyroid, pituitary, ovary and testis for infertility problems.

This brief survey deals principally with the female since there remain great gaps in our knowledge of testicular inadequacy and its treatment.

GENERAL CONSIDERATIONS

We owe to Meaker the concept that the theoretical "fertility index" for any given couple is a flexible rather than a static measure of their ability to reproduce. This index takes into account all the factors in each of the pair that might depress their physical integrity below an absolute optimum, as well as any specific defects of their reproductive organs. MacLeod has recently shown, for instance, that staphylococcus pneumonia and chickenpox were equally effective in a temporary depression of previously normal spermatogenesis to a point close

SUMMARY

The correction of endocrinopathies of the pancreas, parathyroids and adrenals may concurrently alter in a beneficial way the "fertility index" of a sterile couple, but there is no evidence that the secretions of these glands have any but an indirect bearing on the specific function of the reproductive organs.

The consensus of clinical opinion gives weight to the use of thyroid, not only in the presence of frank pathology of this gland, but also in an ill defined zone of hypothyroid states.

Preparations of pituitary gonadotropins now available have not conclusively proved to be of any value in the management of sterility.

It is likely that extracts from human postmenopausal urine, although theoretically safe, will be found impractical to prepare commercially for general use.

Chorionic gonadotropins, also ineffective in production of ovulation, may be of some value to augment deficient corpus luteum function.

Estrogen in small doses may be found effective to stimulate the secretion of favorable mucus from the endocervical glands, and theoretically the same therapy may enhance tubal and uterine physiology.

Progesterone alone, or in combination with estrogen, effectively induces artificial flows which may prove beneficial in some cases of amenorrhea associated with sterility. Otherwise it is of little help except as a possible aid in the latter half of the cycle when a poorly differentiated endometrium suggests that proper implantation of an embryo is unlikely to be achieved.

Recent work on the "rebound phenomenon" after testosterone therapy in some oligospermic males suggests that this may be of no more value than any other endocrine regime to enhance male infertility with the exception of thyroid.

If this brief review accomplishes little else, I hope that it is successful in calling attention to the inadequacy of our knowledge of the mystery of reproduction, pointing out the maze of "Ifs, Ands, and Buts," that plague the earnest investigator in the field of infertility.

to zero. The results of chronic debility are clearly seen in any systemic circumstance or condition causing semistarvation. Women in the prison camps of Germany during the last war became amenorrheic, and soldiers surviving the "death march" from Bataan were impotent, both probable examples of the long recognized inability of the basophilic cells of the anterior pituitary to produce gonadotropic hormones in the presence of vitamin B or protein-intake deficiencies. In a similar category of systemic causes for a lowered fertility index, disease of parathyroids or pancreas may play a secondary role, and endocrine therapy of an uncontrolled diabetic at times may assume primary importance in management of a barren marriage.

ADRENAL GLAND

Ever since the magic twin compounds ACTH and cortisone have come into clinical use, gynecologists have hopefully looked for proof of a possible direct adrenal-ovarian relationship. To be sure, correction of frank, adrenal insufficiency, as in Addison's disease, by appropriate corticoids may permit the return of menstruation so often lacking in this condition. This result probably reflects an improvement of the pituitary cachexia rather than a direct action on ovarian physiology. In Cushing's disease, an absence of menses again very likely represents a relative protein starvation of the hypophysis or else as in some cases of adrenal hyperplasia or neoplasm, an inhibition of pituitary function by excessive levels of adrenal cortical hormones.

In the last few years following observations by Wilkins in Baltimore, Buxton, Jones and others have explored the possibility that the condition loosely described as the Stein-Leventhal polycystic ovary syndrome, and characterized by amenorrhea, hirsutism and obesity may have a dual etiology. Some of these usually sterile women show increased values of urinary corticoids. Buxton has proposed the use of cortisone, 50 mgs. daily by mouth for 30 days as a test of adrenal hyperactivity as the primary abnormality. Under this regimen some of the cases show a return to normal values of 17 ketosteroids in the urine, indicating that cortisone has successfully suppressed the patient's own ACTH and thus affected the hyperactive adrenal gland. In these cases one may look for a return of menses, and when conception occurs it bears proof that such menstruation is physiologic and normal. In other cases, however, the cortisone test will fail, thus directing attention

to the abnormal polycystic ovaries as the source of abnormal steroid production. Whether or not the ovary itself, or the pituitary may be primarily at fault, in these cases wedge resection of the ovaries should be tried. In either case, there is, as yet, no clinical evidence that therapy with adrenal steroids could have any direct action on the ovary or testis or their secretions. It is worth noting that in the laboratory, Hisaw, Velardo, and coworkers have shown an inhibition of the action of estradiol, and also that of progesterone, with DOCA and cortisone acetate in the uterus of the rat. As these effects are further clarified, we may find a competitive interaction of these steroids can be of vital importance in the proper preparation of the endometrium for implantation.

THYROID

The thyroid holds a rather unique position in relation to infertility. Frank myxedema or thyrotoxicosis are generally associated by clinicians with gross menstrual irregularities although the mode of action is none too clear. A recent investigation in the female, including endometrial biopsies and pregnandiol determinations, provides some evidence that in acute hyperthyroidism the commonly decreased flow is an endometrial effect since ovulation may still occur with some regularity. In myxedema, however, this study indicates that ovulation often is inhibited. When a euthyroid state is achieved in either condition—and indeed, sometimes under therapy anticipating the normal thyroid status—ovarian function often resumed a normal and ovulatory cyclicity. Even when frankly pathological thyroid dysfunction cannot be recognized, it is usual for those treating sterility to emphasize the importance of basal metabolism or other evaluation procedures. Not only is this stressed in order to pick up the occasional occult myxedema or Graves' disease, but also because many clinicians advise thyroid in small doses in the management of infertility for any patient with a basal metabolic rate that is at all below accepted normal levels. Indeed, the presence of any characteristic symptoms of thyroid lack is often considered justification for therapy. Some are furthermore convinced that thyroid to tolerance is beneficial in the normal male even though an improvement in sperm concentration, motility or morphology cannot always be demonstrated. The impression has been gained that the metabolism of the spermatozoa may be improved by such thyroid as explanation for a number of otherwise untreated

couples that have successfully achieved conception. Such an extension of the use of exogenous hormones in apparently euthyroid states is open to strenuous criticism by those who claim that homeopathic doses are useless and that anything larger creates a real danger of damping the thyroid-stimulating hormone and producing eventually a dependence on artificial substitution treatment. This wide divergence of opinion has not yet been satisfactorily resolved.

GONADOTROPINS (A) PITUITARY

When gonadal inactivity as a cause for sterility is due not to ovarian or testicular failure—as at the climateric—but to lack of pituitary stimulation, then substitutive gonadotropic therapy should theoretically be the treatment of choice. The definitive diagnosis is made by testing for excretion of the gonadotropic complex. A high titer indicates gonadal failure, while a negative response of immature mouse ovaries to appropriate dilutions of purified urinary extracts indicates at least relative pituitary insufficiency.

In some cases of amenorrhea tests have shown an absence of urinary gonadotropins, yet the patients have been completely normal in all other respects and it has been necessary to make a diagnosis of idiopathic gonadotropic deficiency minus any other failure of anterior pituitary hormones. It is for these rare cases especially that gonadotropic preparations are specifically needed. Thus far the synthesis of such large protein complexes appears to be a long time away. There are only two possible sources of pituitary gonadotropins for clinical use—one, derived from the hypophysis of slaughter house animals, carries with it the probability of antihormone development which automatically limits the repetition of its use. Furthermore, the purification procedures that have to be used before these substances are appropriate for clinical trial significantly alter or reduce the potency of the material. Finally, there is found a marked species difference in response to all gonadotropic preparations. These three reasons explain why there has been thus far no substantiated evidence that commercial preparations from animal pituitaries have ever consistently caused ovulation in the human. The other source of pituitary gonadotropins is the factor that can be isolated from human postmenopausal urine. Recent work suggests that it may be possible to concentrate and purify this substance without too great a loss of potency; if this promising source proves effective, it would not have

the major disadvantages of the animal derivatives mentioned above.

(B) CHORIONIC

Extracts from human pregnancy urine or serum contain a non-antigenic factor that appears to be chiefly luteotropic in effect. Although this hormone from early human pregnancy urine is effective in causing ovulation in intact immature rodents (the Friedman test), unfortunately it does not appear to be able to bring about ovulation in women with anovulatory cycles. Earlier dramatic results from a combination of animal pituitary preparations followed by chorionic gonadotropins have not been consistently corroborated. Although occasionally the use of chorionic gonadotropin in amenorrhea is followed by a menstrual flow, it has proved a disappointing failure in aiding women to ovulate spontaneously. On the other hand, the investigations of Brown and Bradbury show that this hormone may have clinical value in the management of some cases of infertility associated with inadequate corpus luteum function. These workers found relatively huge amounts—a minimum of 10,000 i.u. daily—to be effective in enhancing and prolonging the lifespan of a normal corpus luteum and creating a temporary condition of pseudopregnancy. At the same time they demonstrated its complete ineffectiveness on an immature, or a degenerating corpus luteum. Several reports have called attention to histologic evidence in the endometrium of corpus luteum deficiency. Even though ovulation may occur, there may be a rapid necrosis of the corpus, or a production of progesterone insufficient to cause homogeneous endometrial differentiation into a normal progestational pattern. Possibly in some cases the endometrium itself is relatively unresponsive to “normal” progesterone secretion. In any event, these endometria shows a varied picture best described as “irregular ripening” and such could without much doubt interfere with the chances of implantation of otherwise normally segmenting embryos. Frequently “irregular ripening” results in prolonged or profuse flow; as a cause of functional uterine bleeding this “well defined entity” has an incidence of about 4 per cent. It would appear that chorionic hormone in huge doses might be helpful in these cases if started before degeneration of a corpus luteum sets in, and continued until the time that the embryonic cytotrophoblast is securely functioning. Other than its possible use in some of the individuals who

habitually abort, the value of this substance is presumably limited to these conditions in the female.

In the male, chorionic gonadotropin has proven effective in stimulating spermatogenesis in selected cases of oligospermia associated with low or absent urinary gonadotropins. It may be valuable in the treatment for impotence in the presence of normal spermatogenesis. It does not have gametogenic properties in the human if there is present a high value of FSH, even though spermatogenesis can be preserved after hypophysectomy by its immediate use in some experimental animals.

OVARIAN HORMONES (A) ESTROGENS

The fundamental importance of estrogen in establishing and maintaining the circulation and physiologic function of all the tissues of the female reproductive tract has led to its trial in many circumstances related to infertility. These include therapy directed towards improved function specifically in the cervix, in the uterus and tubes and of the ovary itself.

CERVIX

In the normal menstrual cycle, estrogen production shows a biphasic curve. The first peak is associated with the rapid spurt of growth of the maturing follicle just before ovulation. The second is seen at the height of corpus luteum function 7 to 10 days later. The endocervical glands react vigorously to the first estrogen peak with outpouring of mucus that is profuse, watery, and easily penetrable to spermatozoa. At the time of the second peak when progesterone is also present, the mucus is thick, viscid and relatively impenetrable. Clinical appraisal of the appearance of the mucus is usually sufficient with experience to judge its adequacy. A postcoital test that shows only rare spermatozoa present in the cervical canal, when taken within one or two days of presumptive signs of ovulation and after the semen specimen has been found normal, at once suggests that the cervical mucus may be faulty. Recently attention has been called to the estrogen-induced "fern" pattern of dried mucus which is not seen when estrogen is at a low level, or when progesterone is also present. Inadequate mucus is either due to a low estrogen level at this time, or to unresponsive endocervical glands. The latter may be developmentally inactive or injured by present or prior disease, by childbirth trauma or surgical measures.

Under such circumstances estrogen therapy is

indicated through the first half of the cycle. The daily dose is limited by knowledge of the effect of estrogen on gonadotropin production. In most women an oral dose of any estrogen of the order of magnitude of stilbestrol 1 mg. daily will be sufficient to deplete or suppress gonadotropins; during such treatment, then, no follicle can mature and the purpose of therapy will thus be contravened. As little as 0.25 mg. stilbestrol in unusually sensitive individuals occasionally may influence the pituitary. To increase cervical mucus, therefore, no more than 0.2 mg. daily can usually be taken.

UTERUS AND TUBES

The presence of an "infantile" uterus together with other stigmata of genital or mammary hypoplasia has long been associated with sterility and treated with prolonged estrogen therapy. However, a study of 113 women with "normal" pelvic organs contrasted with 147 patients with undeveloped uteri showed that 66 per cent of the former, and 70 per cent of the latter conceived. It is possible that the importance of genital hypoplasia has been unduly stressed in the past.

Estrogen does play an important role in two aspects of uterine physiology—in its influence on tubal and myometrial contraction waves, and in what has been termed the "intrinsic metabolism" of this organ. It appears that peristaltic waves toward the uterus are initiated in the fallopian tubes which serve as lateral pace makers for uterine contractions which sweep down the fundus to the cervix. The fact that such contractions occur with somewhat greater force and frequency during the preovulatory peak of estrogen production suggests that they may be intimately concerned with keeping the passages cleared of mucus plugs and debris, and favoring the transport of spermatozoa. Kymographic tracings of the pattern of tubal contractions after the menopause show a decrease in tone, range and rate. If estrogen is to be tried in an effort to improve tubal peristalsis, the same limitations to daily dosage apply as that mentioned with regard to improving the cervical mucus.

Almost nothing is known of the specific role of estrogen in functional alterations of endometrial metabolism that may be responsible for some cases of sterility and early abortions. Cyclic changes of certain enzyme systems have been correlated with ovarian activity. The presence of a "priming" stimulation by estrogen is recognized as a necessity for the endometrium to be able to respond to progester-

one. It is possible that estrogen in small doses might have a favorable effect for this reason in some cases in which premenstrual endometria show a poorly differentiated secretory effect. Further basic knowledge of endometrial and tubal physiology and secretions is necessary before such therapy can rest on any scientific basis.

OVARY

The peak output of estrogen associated with the preovulatory spurt of follicle growth has been associated in the rat with a release of pituitary gonadotropin presumed to be responsible for ovulation. Other investigations have suggested that either estrogen or its inactivation products may be responsible for the release of effective luteinizing hormone necessary for ovulation to occur. A single large dose of estrogen early in the cycle postpones ovulation, and this effect has been considered by some to be due to gonadotropic suppression. Brown and Bradbury, however, have investigated an alternate possibility, that estrogen may cause such a release of luteinizing hormone from the anterior pituitary that the latter becomes depleted. Postponement of ovulation then represents a resting period or an exhaustion effect.

A few observations have shown the possibility that these effects may be put to use. In a sterility patient who showed by temperature chart and several negative pregnanediols that over eight consecutive months no ovulation had occurred, was given a pituitary-suppressing oral dose of estrogens for 6 weeks. With the thought that a rebound of gonadotropic activity might occur directly after cessation of this prolonged suppression, a second, single shot of estradiol was given 14 days later. In the meantime, of course, a few days of estrogen-withdrawal flow occurred. Directly following this single shot, however, an excellent rise in temperature was seen; this lasted 2 weeks and a urine specimen was positive for pregnanediol. This presented an opportunity to time the ovulatory phase to increase chances of conception. It has been repeated two times in two different patients, neither of whom as yet, I am sorry to say, has conceived. Theoretically, this use of estrogen appears promising and should receive further study.

(B) PROGESTERONE

The complaint of amenorrhea or oligomenorrhea presents a problem that is particularly difficult to

treat successfully when conception is the primary aim. Uterine bleeding can generally be induced, but the major difficulty is to bring about spontaneous ovulation. Absence of menses to the age of 18 generally indicates only the delayed menarche of a late maturing adolescent. When there have never been any periods in a wife over 20, serious difficulties can be expected. Congenital aplasia of the ovaries will be suggested by the multiple and bizarre physical defects usually present in this syndrome such as short stature, webbing of the neck, coarctation of the aorta and so forth. Congenital aplasia of the uterus occasionally is found. Symptoms of virilism may suggest adrenal cortical hyperfunction, "internal" hermaphroditism or masculinizing tumors of the ovary. None of these conditions is likely to promise any possibility of later pregnancy following endocrine treatment.

Secondary, or acquired amenorrhea—as well as irregular cycles or prolonged flows—all these three are frequently associated with infertility. When tumors, infections, tuberculosis, endometriosis and other organic pelvic diseases have been ruled out, there is one common denominator to this triad of complaints—in all, the primary deficiency is failure of ovulation and consequently a nonproduction of progesterone. In all three, endocrine therapy may offer the only logical avenue of approach, yet thus far such treatment has proved often ineffective and unpredictable in its results.

One syndrome that must be excepted from this statement is the Stein-Leventhal polycystic ovary syndrome. Aside from the previously mentioned use of cortisone, hormone therapy is unavailing; surgical measures are indicated to make it possible for ovarian follicles to break through the thick cortex typical of the condition.

It might almost be considered axiomatic that if indubitable evidence of ovulation by endometrial biopsy, urinary pregnanediol and basal temperatures is obtained, then some dysfunction other than that of the pituitary-ovarian axis must be suspected to explain cycle irregularities characterized by menorrhagia or oligomenorrhea. The great majority of patients in the third and fourth decades complaining of amenorrhea are not suffering from what they most fear—an early menopause. Generally ovarian follicles are present and estrogen is continuously available and adequately maintaining the reproductive tract. The cause for ovarian failure—except for

the Stein-Leventhal syndrome—must be presumed to lie in deficient gonadotropins. Without effective production of the luteinizing and luteotropic fractions, ovulation will not occur. There are as yet no practical laboratory techniques widely available to assay for these hormones. There are also no commercially available pure compounds to be used for substitution therapy as stated previously. A number of clinical reports document the possibility that emotional tensions and psychosomatic states by an ill defined mechanism may control the release of pituitary LH. Some cases may resume normal cycles after confident reassurance alone. Others need definitive psychiatric investigation. The induction of artificial periods with progesterone alone or in combination with estrogen is almost the only valid method of hormone therapy at present. Reappearance of the menses in itself at times may constitute an element of psychotherapy. In some a series of artificially induced episodes of uterine bleeding may be followed by spontaneous and occasionally ovulatory cycles. It must be expected that relapses to amenorrhea will probably recur, and repeated courses of ovarian steroids must be given. For such treatment the first trial should be with progesterone alone. If the endometrium is properly primed by sufficient endogenous estrogen, then a course of progesterone will be followed in approximately 48 hours by progesterone-withdrawal flow; 5 mgs. in oil intramuscularly or 20 mgs. absorbed through the buccal mucosa or 50 mgs. of anhydro-hydroxy progesterone, each given daily for four days, are about equally effective. When this proves to be a satisfactory dose, it should be repeated at 28 day intervals for 3 or 4 months. If ineffective, then ovarian function should be augmented with estrogen as well as progesterone. The dose of estrogen may have to be established by trial and error according to the individual's needs. Usually an amount equivalent to one or 2 mgs. of stilbestrol a day for three weeks will be sufficient, when followed by progesterone as suggested above, to provoke withdrawal bleeding even in recalcitrant cases. Frequently the estrogen dose may be cut down in successive cycles. There have been excellent results reported from combining estrogen and progesterone in a single intramuscular injection in some cases. The dose recommended has been about 2 mgs. of estrogen to 12 mgs. of progesterone. The prognosis for pregnancy in these cases is never good, but the need for relief from emotional tension that can be gained by reassurance

is a justifiable indication for patient and prolonged hormonal management.

Other indications for use of progesterone therapy in sterility are limited to the possibility of enhancing the endogenous production of this hormone where corpus luteum deficiency is suspected. The possible use of chorionic gonadotropin in large doses for the same purpose has already been discussed. The only gauge of endogenous progesterone levels is the recovery of the daily quantity of its urinary excretion product, pregnanediol. In apparently normal women this varies from 0.3 mg. to 6 mg. during the luteal phase from day to day. Recovery experiments suggest such values indicate as little as 10 per cent of circulating progesterone. It may then be postulated that a daily dose of 20 to 40 mgs. intramuscularly might be considered in the neighborhood of an augmentation dose for a deficient corpus luteum from day 15 to day 25. After that, on the supposition that implantation may have occurred, it would seem more reasonable on theoretic grounds to use chorionic gonadotropin.

There are no indications at present for the use of estrogen or progesterone in the treatment of male infertility.

TESTICULAR HORMONES

Although frigidity for the most part is psychosomatic in etiology, the response from small daily doses of testosterone in the female may prove gratifying evidence that a physical component is also involved. The dose should be never more than 10 mgs. of methyltestosterone daily, and if any tendency towards hirsutism becomes evident, treatment is best suspended.

In the human male, except for the use of chorionic gonadotropin, there has been until recently no hormone therapy that has had any effect on increasing spermatogenesis or improving in other characteristics the quality of semen. Testosterone has been known to decrease urinary gonadotropins and secondarily depress testicular function. In 1950, Heler, Nelson *et al.* showed that Leydig cells disappeared and germinal cells decreased after daily injections of 25 mgs. of testosterone propionate over the course of 4 to 13 weeks. However, in these normal males, testicular biopsies 17 months later exhibited an appreciable improvement in testicular morphology. This rebound phenomenon unfortunately has not been confirmed in the treatment of oligospermic males, and at present promises little in relation to male infertility.

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GELATIN IN THE TREATMENT OF BRITTLE NAILS

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As is true of medicine in general, there are many minor conditions in dermatologic practice which are very common but which receive scant attention due to their apparent unimportance. Also because of their relative unimportance, little has been written on them. Even in text books the references to them are apt to be vague and the treatment outlined non-specific. In a way we treat these conditions by a wave of the hand or a shrug of the shoulders, or the advice to the patient to forget it.

The brittle, splitting nail is just such a condition. Of great importance to a woman who is meticulous in her appearance and fastidious about her hands, it can be a vexing and embarrassing therapeutic problem to the physician who is confronted by it and has no means to combat it.

The brittle nail as considered here is one in which the free end is fragile, peels, chips, or splits into lamina much like mica (Figure 1) preventing the manicuring of the nail to a nicely rounded point. It gives the free end of the nail a step or terraced appearance. These defects occur with or without other pathology of the nails or the skin or the body in general being present.

A definite distinction must be drawn here between a nail which is apparently normal but splits in layers (laminae) as in most of our cases and a nail which is bitten, torn, or otherwise traumatized so that it has a sawtooth edge; with these latter we are not concerned as they have no therapy.

The brittle laminating nail without other nail

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SUMMARY

Twenty-six of thirty-six cases of brittle laminating nails were improved after taking gelatin for three months.

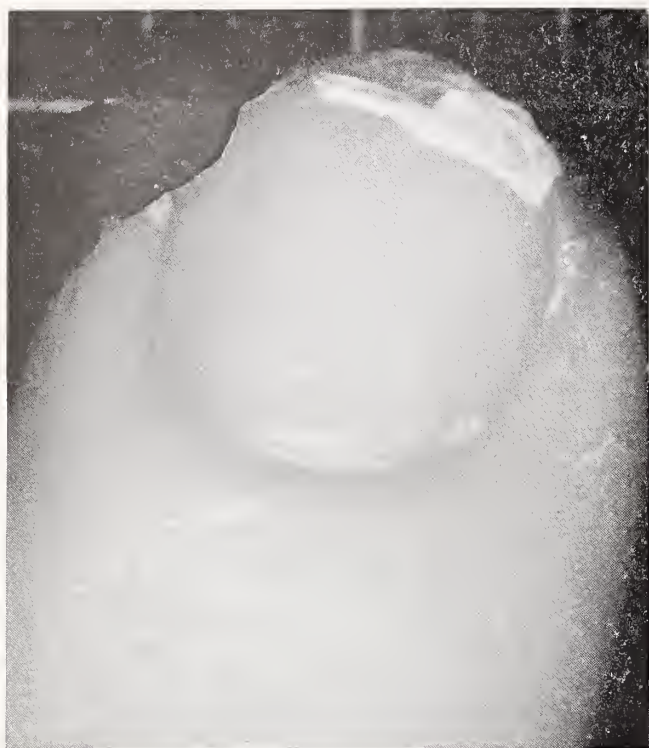
Three cases of brittle laminating nails in diabetics were unimproved after taking gelatin for three months.

All five of the psoriatic nail cases were improved on gelatin.

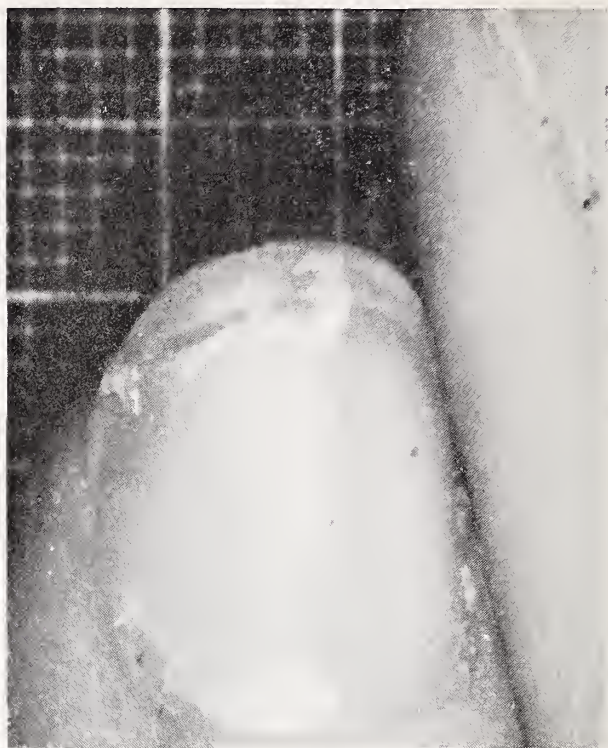
Congenital nail deformities were not affected by gelatin.

pathology is very common among housewives, having a reported incidence of 45.2 per cent.¹ This frequency is, however, greater than the cases met in our office practice would indicate.

In 1950, Tyson² reported improvement in eleven cases of brittle nails when gelatin was made part of the diet. Since then no written report has appeared on the effects of gelatin on the fingernails, although it is frequently advised as treatment on an empiric basis.^{3,4,5} Because so many women asked our advice about their nails, we decided to investigate further the effects of gelatin.



A



B



C



D

FIGURE 1
Types of brittle nails; A and B: showing laminating;
C: showing breaking off of the free edge; D:
psoriasis

METHOD

Our cases were unselected in that we used the therapy on each nail case that came to the office excluding only onychomycosis. This was excluded because we felt we could not afford to withhold other forms of local therapy for the required time to grow a new nail, and to combine gelatin and other treatment would in the end obscure the effect of either. The gelatin was packed in envelopes each containing 7 Gm. It was decided to give the patients the gelatin in multiples of this dosage form.* Most patients, however, were put on a regime of one envelope containing 7 Gm. of gelatin daily. Fifteen weeks was decided as the optimal time, since in most cases that would be the length of time a nail would take to grow its full length. The patients were instructed to take the gelatin either in water, fruit juice, or milk. Most patients found this method of administration quite satisfactory.

A small hole was bored in the proximal end of the nail at the cuticle as a permanent mark so that the rate and end point of growth could be measured. The condition of the nail and any other accompanying medical conditions were also noted. The nails were photographed at the end of each month against a millimeter-ruled graph paper and the rate of growth noted in that way. The patient was asked to demonstrate the splitting by snapping the fingernail against the thumbnail causing it to laminate. Except for taking the gelatin the patients were instructed to carry on their daily routine exactly as before. Neither the use of nail polish or strong household chemicals was discontinued except in those cases where eczematous lesions of the hands were present. Because all of our patients were ambulatory we had to rely on their statements about the actual ingestion of the gelatin. It was our impression that most cases were trustworthy in this respect, with few exceptions. Because we felt we should have some cases in which it could be certified that the medication was taken as prescribed, eight cases of normal nails were selected as controls among residents of an old age home. They were all over seventy-five years old and their diet was under the supervision of a nurse. Several of the cases were hand fed.

Various types of tension instruments and thickness gauges were tried in the hope that some method could be devised which would reliably measure the

thickness and pliability of the nail, but it was found impossible to achieve any degree of constancy in these readings. These procedures were therefore abandoned and only the end result as witnessed by the photographs and the patients' and our own observations was considered.

RESULTS

In total, forty-four cases were put on gelatin therapy (see Table I). Of these, eight were controls and had no pathology other than the longitudinal ridging commonly seen in old age. Their nails were unchanged at the end of three months. Of the remaining, thirty-six had splitting nails. Twenty-six of these showed much improvement in that splitting stopped and the nails could be manicured to a point after gelatin therapy. One case was considered slightly improved in that splitting of the nails into laminae stopped, but chipping and breaking off at the corners continued. Nine cases were considered failures. Of these nine failures, three took the medication for a month or less. One case which had no improvement at the end of three months nevertheless persisted in taking the gelatin and had definite improvement at the end of five months. Two of our failures had congenital or familial disease of the fingernails, and three were diabetics. Of the twenty-six improved cases, the most striking improvement was in five psoriatics whose nails showed remarkable clearing though there was no perceptible influence on the lesions of the rest of the body.

TYPICAL CASE HISTORIES

NO. 2

S. D., 36, white, female, housewife—two children—suffered with lamination of the nails for about twenty years. She was unable to get a proper manicure. In addition, she had chronic nephrosis and albuminuria. After three months of 21 Gm. of gelatin by mouth, her nails had smooth edges, there was no lamination, and she volunteered the information that for the first time she was able to properly manicure her fingernails. There was no effect on either the nephrosis or the albuminuria.

NO. 6

I. E., 34, female, factory worker—laminating of the nails since childhood. She is in excellent health otherwise. After taking 21 Gm. of gelatin for three months, her nails improved and manicuring was possible. No splitting occurred. Her condition has remained the same, unchanged, even three months after the discontinuance of gelatin (Figure 2).

NO. 11

M. D., age 70, nurse—nails laminated at the free edge for many years. Otherwise healthy. After three months of

*The gelatin used in this experiment was furnished by Knox Gelatin Company through the courtesy of Dr. D. Tourtelotte.

TABLE 1

NO.	INIT.	AGE	SEX	OCCUPATION	CONDITION OF NAIL	RESULT	OTHER CONDITIONS	REMARKS
1	HM	59	F	Hwf.	Laminating and ridging	Improved	Stasis ulcers	Ulcers no effect; no effect on ridging; took 21 G. daily
2	SD	36	F	Hwf.	Laminating	Improved	Chr. nephrosis and albuminuria	No influence on nephrosis Took 21 G. daily
3	BC	64	F	Hwf.	Laminating and splitting	Improved	Arthritis and hypertension	Arthritis—no effect; hypertension—no effect; took 21 G. daily
4	WB	62	M	Exec.	No splitting—extremely soft—pain	Unimproved	None	Took only one month; took 14 G. daily
5	HR	39	F	Hwf.	Hard nails—nails chipped not laminated	Unimproved	Endometriosis Bilat. ovariectomy	Improved after 5 months; chipping from trauma—took 21 G. daily
6	IE	34	F	Fac. wk.	Laminating	Improved—Manicuring possible	None	Condition present since childhood; took 21 G. daily
7	EK	62	F	Fac. wk.	Laminating and chipping	Unimproved	None	Question of actual ingestion
8	RB	25	F	Hwf.	Laminating	Improved in 2 months—Obesity	None	Obesity unimproved; took 21 G. daily
9	MC	22	F	Fac. wk.	Laminating and splitting	Unimproved	Psychoneurotic	Could not tolerate
10	TS	21	F	Fac. wk.	Laminating and splitting	Unimproved	Psychoneurotic	Could not tolerate
11	MD	70	F	Nurse	Laminating	Improved	None	Improved in spite of nursing routine
12	MF	84	F	Retired	Laminating and chipping	Unimproved	Diabetes	Chipping from trauma
13	CR	42	F	Hwf.	Laminating	Improved after one month	None	Took 14 G. daily
14	MB	32	F	Hwf.	Laminating and splitting	Improved	None	Laminating recurred but stopped on resuming gelatin
15	LG	38	F	Hwf.	Nails soft, laminating	Improved	Derm. herpetiformes	Nails remain soft—derm. herp. unaffected
16	MC	73	F	Hwf.	Nails extremely thick pitted; psoriasis of nails	Improved	Senile atrophy of the scalp—Alopecia	Alopecia unaffected—x-ray and other treatment of the nails previously had failed
17	NL	49	F	Jan.	Nails thick, laminating	Improved	Lichen sclerosis et Atrophicans Ophiasia Alopecia	Other condition unaffected
18	AG	38	F	Hwf.	Onychodystrophy	Unimproved	Neurodermatitis scalp	Familial congenital
19	IP	34	F	Hwf. Sl. clk.	Laminating	Improved	None	Improved in spite of working in hardware store
20	SC	35	F	Hwf.	Nails thin, soft no laminating—marked ridging	Unimproved	None	Condition is congenital—familial—seven year old daughter has identical nails
21	RG	36	F	Hwf.	Nails thick—laminating	Improved	Seborrheic scalp	Seborrhea unaffected
22	LN	34	F	None	Nails very thin, very soft, laminating	Unimproved	Diabetes lifelong. Mult. keratosis, seborrheic scalp	No other condition affected by gelatin—nails still soft

TABLE 1—Continued

NO.	INIT.	AGE	SEX	OCCUPATION	CONDITION OF NAIL	RESULT	OTHER CONDITIONS	REMARKS
23	AT	40	M	Tr. dr.	Pitted and transv. grooves	Improved	Extensive psoriasis	Other lesions of psoriasis unaffected
24	BM ^c	52	F	Of. wk.	Painful finger tips Oncholysis	Improved	Sub-acute lupus ery.	Nails grew out without separating from bed
25	SM	55	F	Of. wk.	Laminating and splitting	Improved	Epithelioma of the lip	
26	HR	40	F	Hwv.	Brittle, splitting nails	Improved	Neurotic excoriations Essential pruritus	Pruritus unaffected
27	MM	26	F	Hwv.	Hard, transv. ridging, wash-board appearance, laminating	Improved	Chronic eczema of the hands and fingers	Laminating stopped—eczema and sequelae on the nails not affected
28	EH	46	F	Hwv.	Nails extremely thick pitted, curled	Improved	Widespread psoriasis	Psoriasis unaffected
29	EM	18	F	School	Nails extremely thin, soft, brittle, spooned, laminating	Improved	Seborrheic Alopecia	Thickness of the nail unaffected; Alopecia unaffected
30	AM	38	F	Hwv.	Brittle, splitting, hard	Improved	Nail condition appeared after first attack of cholecystitis 1 year ago	
31	JG	37	F	Hwv.	Nail hard laminating	Improved	None	
32	RS	47	F	Hwv.	Nails hard laminating no evidence of psoriasis	Improved	One lesion of psoriasis on neck	Psoriasis not affected
33	RO	93	F	None	Long. ridging	No change	Cereb. arterio. scl.	Semi-coma
34	JM	85	M	None	Long. ridging	No change	Primary anemia	No effect on anemia
35	EP	82	F	None	Long. ridging	No change	Hemiplegia	Nails checked were on normal side
36	JJ	90	M	None	Long. ridging	No change	Constricting oesophagitis	No change
37	CJ	80	F	None	Long. ridging	No change	Per. agit.	No change
38	AL	89	F	None	Nails smooth, hard	No change	Per. vasc. dis.	No change
39	BB	73	F	None	Long. ridging and splitting	No change	Hemiplegia ovarian cyst—diabetes	No change
40	HG	88	M	None	Trans. grooving Psoriasis of nails	Improved	Fractured hip Psoriasis	Other conditions—no change
41	AM	76	F	None	Long. ridging	No change	Decomp. cardiac	Cardiac condition—no change
42	AC	89	M	None	Long. ridging	No change	Prostatectomy	Unchanged
43	AC	55	F	Hwv.	Hard, laminating	Improved	Hypertensive cardiac Chr. Paronychia	Paronychia cleared by x-ray
44	EB	34	M	Tr. dr.	Transverse grooves and pits (psoriasis)	Improved	PS knees and elbows	Only nails improved

gelatin, the nails were normal and have remained normal to the present (Figure 3).

NO. 16

M. C., age 73, housewife—complaining of extremely thick and pitted nails of ten years' duration and loss of hair. There were no other skin lesions present. The scalp showed a loss of hair with atrophy of the scalp itself. Biopsy of the scalp showed extreme senile atrophy. The nails were extremely thick, unbending, dark and pitted by vertical rows of deep indentations. There was a great deal of subungual debris. In 1951 patient had had x-ray treatment for the nails which were diagnosed as psoriasis at that time. We concurred in the diagnosis of psoriasis, although there was no other lesion of psoriasis on the body. Patient was put on gelatin. All twenty nails as they grew out were considerably thinner than the old nail, and much smoother. The difference could be seen as a distinct line of demarcation.

NO. 22

L. N., age 34, white, female—diabetic since early childhood and at present controlled by insulin, complained of numerous seborrheic keratoses of the neck and back. Also had extreme seborrhea of the scalp. The nails were noticeably thin, very soft, and the free ends were extremely fragile. The nail split into lamination some of which extended one-quarter of the way back. She was put on gelatin, but at the end of three months there was no improvement.

NO. 26

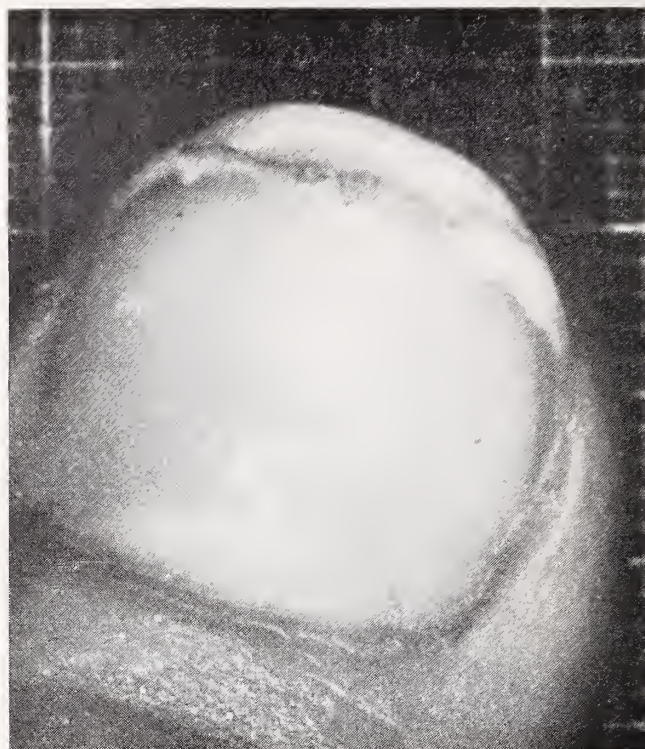
Age 40, housewife—two children—complained of generalized essential pruritus for many years. She had also complained of brittle splitting fingernails for many years but this was always thought to be due to her habitual scratching and neurotic picking. She was put on gelatin. At the end of three months she proudly exhibited her full length manicured fingernails. The essential pruritus was not altered.

NO. 27

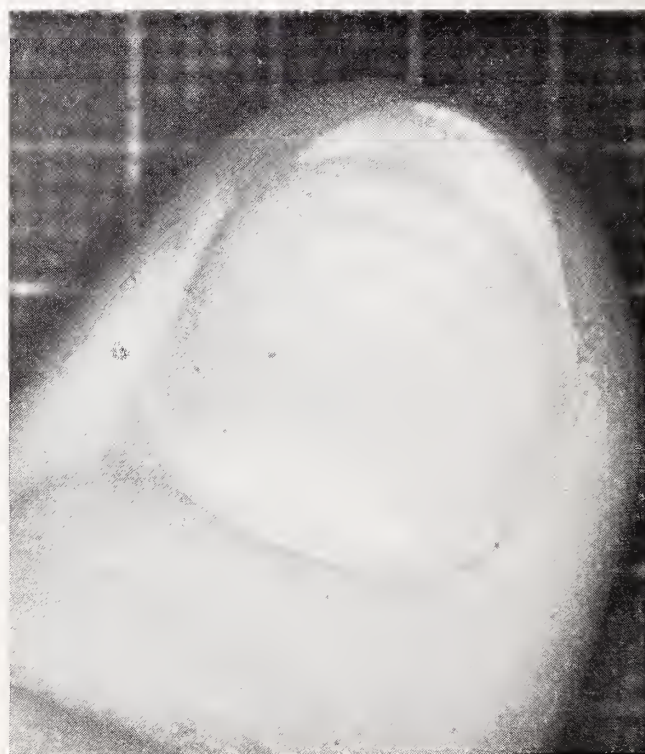
M. M., age 26, white, housewife—three children—has suffered from chronic eczema of the hands (housewives eczema) for the past two years. During the two years the nails also participated in the eczema and were transversely ridged and had a washboard appearance. In the past year her fingernails became brittle and split. The nails, however, were hard and stiff. She had had a full course of x-ray treatment for the eczema. She was put on gelatin. At the end of eight weeks the fingernails no longer split, but otherwise were not changed in any way. The eczema continued as before.

NO. 30

A. M., age 38, housewife—two children—for the past nine months has been under the care of her physician for cholecystitis. About the same time that her abdominal trouble started she noticed that her fingernails were becoming brittle and laminated very easily. Her fingernails were of average thickness but the free ends were jagged and the laminations had split off leaving the peculiar terrace effect. She was put on gelatin with great improvement at the end of three months. Cholecystitis was unchanged.



A



B

FIGURE 2

Case No. 6: showing terraced effect resulting from laminating; A: before gelatin; B: After gelatin

DISCUSSION

Some question arises as to just what constitutes brittle nails. In Tyson's cases² the nails were in general harder than usual. Others have described this type of nail as being thin and soft. Our cases were about evenly divided as to thinness and thickness of the nails. We found nails so thin and soft that they could be bent double, nails so thick and hard that they were used as screwdrivers, both without splitting. Brittleness and splitting may occur in soft as well as in hard nails, but the softness or hardness of the nail does not seem to predispose the nail to brittleness. The nail as it grows out from the matrix probably gathers some thickness by additional layers of keratin added by the nail bed. The body of the nail itself is composed of sheets of hard keratin, welded in compact layers of flat horny scales which are thin in the peripheral and thick in the deeper layers; these are cornified epithelial cells.⁶ The layers are arranged not in horizontal fashion but tangential, so that a layer which starts to peel from the surface of the free edge, tears deeper and deeper into the nail body as it separates proximally. This accounts for the nail almost never peeling all the way back, since it is strengthened by overlying layers. In fact, all the scales of the skin of the fingers are arranged in shingle fashion with the free edges pointing to the tips of the finger so that a small tear at the tip of the finger, if pulled, deepens and becomes painful. This arrangement also accounts for what happens in the formation of a hangnail; the more it is pulled, the deeper and more painful it becomes.

Many theories have been propounded as to the causes of the brittle nail. Pardo-Castello blames excessive manicuring and manicuring chemicals for it.⁷ Other authors have mentioned calcium deficiency,⁸ iron deficiency,⁹ Vitamin A deficiency,^{10,11} Vitamin A excess,¹² hormone imbalance,^{13,14} and household chemicals and detergents as the cause. Klauder¹⁵ has shown that the sulfur content of abnormal nails is lower than in the normal nail. However, since there are only 0.9 per cent of sulfur containing amino acids in gelatin it hardly seems enough to affect the sulfur content of the nail. The statement has also been made that brittle nails are prevalent in the winter and improve in the summer.¹⁶ Our observations have run over a period of



A



B

FIGURE 3

Case No. 11: A: delicate peeling of free edge before gelatin; B: after 10 weeks of gelatin

twelve months and many of our cases improved during the winter months.

Recently Kile⁸ has demonstrated that there was no relationship between the calcium content of the nail and its brittleness. Since our patients were directed to manicure their nails as before and nevertheless showed improvement on the gelatin, we feel that the manicuring and chemical etiology for the splitting is eliminated. We examined the nails of many surgeons, who are great soap and water users, but found no cases of splitting nails among them. Grossly, none of our patients showed any evidence of vitamin A deficiency or hormone imbalance.

Nevertheless, our own feeling is that the condition is in some way related to occupation and metabolism.

Keratin which forms the body of the nail is composed largely of cystine radicals. Gelatin contains only 0.1 per cent cystine, hardly enough to influence greatly the composition of the nail. An analysis of fingernails shows it to contain all its amino acids in very similar molecular proportion to gelatin except for cystine of which the nail has 129 times more than gelatin.¹⁷ Yet pure cystine fed over several months to patients with brittle nails has failed to improve them.¹⁸ Since cystine is practically the only sulfur containing amino acid in the nail it appears that neither the sulfur nor the cystine are important factors in the genesis of the brittle nails.

It is probable that all the amino acids contained in gelatin are ingested by the patients in their ordinary daily diet. Nevertheless, these patients did not improve until they took the polypeptid combination contained in gelatin.

We were at first surprised when some of our patients reported their nails improved long before the entire nail was replaced. We had always considered the nail, like the hair, could not be affected once it had grown out. But on further consideration it appears that certain substances can diffuse through the nail even to its free end. We have seen this happen in patients taking Atabrine, many times, where after a few weeks the entire nail becomes fluorescent indicating the presence of Atabrine in the formed nail. This does not happen with hair. It is entirely possible that other substances can diffuse through the nail and affect its physical qualities. In cases of brittle nails apparently there is some defect in the "vulcanization" of the lamina of hard keratin. Whether this defect is in a "cement substance," if there is one, or in the formation of the "biologic

plastic" of the nail, is a matter of conjecture at this point.

Gelatin is a hydrophilic colloid which in solution has the property of gelling. When its water content falls below 10 per cent, it becomes brittle. The water content of the nail is 10-11 per cent. It is possible perhaps to consider the "cement substance" of the nail as a differently composed gel which might have similar physicochemical properties to gelatin. The hydrolysis of gelatin results in the continuous loss of gel strength. Thus the effect of acids, alkalis, heat or proteolytic enzymes including those elaborated by micro-organisms, can break down the gelatin molecule so completely that it will no longer form a gel. There is no question that the vast majority of brittle nails occur in women. We encountered only three men who had any nail trouble at all, and these had no splitting. Every woman must be considered a housewife, full or part-time, in spite of whatever other occupation she has. In our opinion, brittle nails are one of the occupational diseases of housewives based on a metabolic predisposition of unknown origin. Brittleness, which in nonpathologic cases manifests itself first at the free end of the nail, could conceivably be a result of the above mentioned factors destroying or modifying the "cement substance." This might result in free lamina of keratin which soon break from slight trauma, leading to the terraced effect of the nail. It is possible that by affecting the "gel" or "cement substance" of the nails gelatin may keep them in a normal state.

Weidman¹⁹ in his discussion of Kile's paper suggests a development of parakeratosis in brittle nails. We feel that his observation is especially significant since our cases of psoriasis, and also those of Tyson² showed the greatest improvement with gelatin therapy. Parakeratosis is characteristic of psoriasis. However, other lesions of psoriasis were not affected by the gelatin. It also surprised us to find that the common white spots which we believed to be fixed in the nail can apparently be absorbed before the nail grows out. This was evident especially in one case in which the white spots diminished in size and some disappeared before the nail was replaced.

It was quite apparent that the therapeutic target of gelatin was not alone in the growth center of the nail. Our patients did not grow their nails faster than the predicted rate and, among the selected patients, the rate of growth was the same before and while taking the gelatin. In our case of onychodystrophy

no nail grew, even though a rudimentary growth center and nail bed was present. In none of our cases was the longitudinal ridging affected, unless it was pathological, neither was the thinness nor thickness of the nail influenced except in psoriasis. These characteristics would have been altered if the gelatin had any effect on the growth center. On the other hand, transverse ridging, pitting, and other signs of pathological activities were affected. An interesting aspect indicating a possible mechanism of gelatin action was shown in one case of chronic nephrosis. She had excellent improvement after a lifetime of fragile, brittle nails. It is conceivable that she was previously losing an essential protein component in her albuminuria which was replaced by her gelatin uptake.

We found a remarkable variation in individuals as far as the rate of growth was concerned. In general, the young patients took less than fifteen weeks to replace the nail. One patient took thirteen weeks. The healthy octogenarians who were ambulant took longer than fifteen weeks, and those who were bed-ridden took over eighteen weeks. The authors took one hundred days to replace their own nails. The nails of one patient, who was slowly sinking into a semicoma for the last month of the experiment, grew so slowly that at the end of three months the nail had grown out only one-third of the way. At that rate it would have taken her nine months to replace her nail if she lived.

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THE TREATMENT OF VOICE DEFECTS FOLLOWING SURGERY

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THERE are a number of speech clinics in this country where medical, dental, and educational specialists are working together in the diagnosis and treatment of speech and voice problems. The voice clinic with which the writer is associated provides an example of a team operation which has improved the service to those patients having voice defects, offered better training for students, and extended the scope of research activity. It is a pleasure to acknowledge here that this particular clinic was established as the result of an invitation from and with the assistance of the Department of Otolaryngology of the Northwestern University Medical School.

In speech correction literature the term "voice defects" sometimes refers to all types of speech disorders. Usually, however, it means undesirable deviations in pitch, loudness, and/or quality of the voice. That is, the term concerns the problems associated with the larynx and the adjacent respiratory tract. It is used in this more specific sense in this paper.

PRINCIPLES OF VOICE PRODUCTION

There are certain fundamental theoretical principles of voice production which are essential to the present discussion and which should be reviewed briefly. In normal vocalization, the breath meets the approximated vocal cords and forces them apart, thereby allowing the air to escape until the elasticity of the cords and the reduced lateral pressure resulting from the flow of air closes them. When the air pressure below the cords again becomes great enough to overcome the cord resistance, they are forced open, and so the cycle of vibration is repeated. The alternating flowing and stopping of the breath creates pressure changes in the air of the respiratory tract which are transmitted to the external atmosphere and hence to the ear of the listener. This is essentially the same phenomenon which occurs in any air horn. The faster the air pulsations are released, the higher the pitch which is heard. The rate of vibration is determined primarily by the

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SUMMARY

Voice defects, as distinguished from speech defects, are those audible differences in pitch, loudness, and quality which are atypical of persons in the population of the same age and sex. These voice defects are associated with the larynx and/or the respiratory tract, especially the nasal passages. When the larynx does not operate properly some form of phonatory problem results. When the nasal passages cannot be closed by the action of the velopharyngeal musculature, or when growths occlude the nasal passages, resonance problems are present.

Surgery involving the larynx may either restore the larynx to normal, remove part or all of it, or produce a paralysis. Certain voice re-educative procedures may be instituted in each of these conditions. They include both psychological and physiological activities ranging from motivation to direct exercises. There are also somewhat similar procedures which may assist in the reduction of hypernasality.

It is obvious to those who work with voice defects that more study and research are urgently needed in diagnosis, therapy, and basic theory. This can be accomplished through the cooperative efforts of the laryngological and speech correction specialties.

mass and the stiffness, or elasticity, of the vocal cords.

Another voice variable which is related to vocal cord function is loudness. The loudness of voice is produced by the pressure of the released pulsations. Additional pressure causes an increase in the amplitude of the movement of the air molecules, with consequent increase in the excursion of the ear drum, and hence a louder sound. If, for any reason, the breath flow is not completely interrupted or the air escapes in such a way as to create turbulences, noises are produced which we hear as breathiness or

hoarseness. To reiterate, the vocal lips, activated by the breath, determine the pitch, intensity, and some of the qualities of the voice, especially hoarseness.

Other quality characteristics are resonance phenomena: that is, they are associated with the size, shape, and degree of potency of the passageways through which the breath and sound travel. The most common deviations from normal are recognized as too much or too little nasal resonance in those words where such sounds are not normal. For example, *Sprig* has *cub* for *Spring* has *come* puts non-nasal sounds where nasal sounds are expected in the language. Taken individually, *sprig* and *cub* are completely acceptable. It is the obstruction of the nasal passages, and the consequent change of resonance, which produces the "cold in the head" type of speech. In the opposite condition, when there is an inability to close the velopharyngeal area the result is the nasalization of all sounds. This is the type of speech which sometimes follows an adenoidectomy, and usually accompanies cleft palate, paralyzed palate, congenitally short palate, and the like. Briefly then, the respiratory tract resonates the sound generated in the larynx. Deviations in or intimately related with the nasal passages cause most of the resonance defects. These we recognize grossly as too much or too little nasal resonance.

CONDITIONS PRODUCED BY SURGERY OF LARYNX

The subject of this discussion is the treatment of speech defects following surgery. When surgery related to the larynx has been completed, the structure will either have been restored to normal, or will have been partially removed, completely removed, or paralyzed in some degree. The conditions following surgery in the nasal and pharyngeal areas are more varied, particularly when the maxillofacial problems are included. However, where obstructions occur a patent airway may be achieved by removing growths, and normal speech can follow. Where the nasopharyngeal closure has not been possible, surgery may provide a functioning palate or a lengthened palate; on the other hand, it may result in an inadequate velopharyngeal closure, a maxillofacial deformity, a partial or complete absence of the tongue, and so on. The health-giving surgery often unavoidably produces problems for the speech therapist. There are varying approaches to these speech problems, just as there are to medical problems, and each case must be studied carefully and managed individually in relation to the causes

of the problem and the needs of the patient. There are, however, certain general statements which can be made about speech therapy following operative procedures.

VOICE THERAPY FOR THE EXTROVERT

When surgery results in normal laryngeal structures and the voice has been restored, the logical assumption is often made that speech therapy is not indicated. It has been shown, however, that such training is highly beneficial in those cases where misuse of the voice has been the original cause of the laryngeal anomaly. This would apply to such problems as vocal nodules, some hematomas, those contact ulcers requiring surgery, and thickened vocal cord tissues.

Persons having these problems usually are gregarious, talkative, and athletic (or physically active); in other words, extrovertive. The frequent exception is the individual with contact ulcer, who is usually less aggressive and speaks in a subdued, monotonous, guttural voice in which laryngeal tension is evident.

The voice therapy for these cases follows two intimately related courses: psychological and physiological. First, the patient must be informed, as completely as his ability will permit, of the detrimental effects of vocal abuse, and he must honestly desire to change his vocal habits; second, he must be motivated toward both the immediate and the long-term goals of regular practice and controlled voice production; third, concrete, specific suggestions should be given for limiting voice use; and, fourth, he must be taught how to phonate in a relaxed manner without unnecessary muscular tension in the larynx. The basic approach in the fourth objective is to teach an aspirate initiation of the laryngeal tone, combined with a slight change of habitual pitch level. The aspirate attack causes the vocal cords to approximate gently, thereby lessening the intercords pressures and rubbing. The pitch change probably contributes most by keeping the subject aware of his speaking process and by forcing a change of laryngeal adjustments.

SPEECH TRAINING FOLLOWING PARTIAL REMOVAL OF VOCAL CORDS

When a part or all of a vocal cord has been removed surgically, the voice is usually seriously impaired. This occurs because the air stream cannot be interrupted adequately, and the more or less continuous flow of the air creates extraneous noise. Careful study of the laryngeal potential is necessary, followed by a planned program of therapy to com-

compensate for the loss. Sometimes scar tissue growth will help to form a closure. Whether it does or not, the unimpaired cord can usually be trained to go beyond the midline, and after some months may be able to contact the remainder of the opposite cord. This training for compensation includes regular and frequent attempts to phonate, gentle pseudocoughing, and attention to pitch changes. Such temporary adjustments as turning the head to the affected side or pressing on the thyroid lamina will often bring the cords closer together and thereby improve the voice. This serves the dual purpose of easing telephone or difficult conversational situations, and of providing a certain incentive for additional practice.

Some of these patients learn to use their ventricular bands and other superior laryngeal structures for phonation. One woman, seen in our clinic, who had had extensive surgery on her cords when she was an infant and whose true cords are now composed primarily of scar tissue, had learned to approximate the ventricular cords similarly to the manner of true cord approximation. Another patient, with one cord and a section of the other removed, developed a substitute phonatory mechanism in which the superior part of the larynx contracted in a sphincter-like movement. The air stream activated the arytenoids, the epiglottis, and the ventricular cords to produce the voice, which, of course, was hoarse. The laryngeal conditions of the patients who have had a laryngofissure operation differ considerably from one to the other, yet they all seem capable of developing some sort of voluntary constriction which can be vibrated by the breath stream.

The speech training for persons with partial removal of the sound-producing mechanism has three purposes: (1) to keep the person practicing and trying to improve; (2) to help him accept his hoarse voice and to avoid undue discouragements; and (3) to provide progressive exercises while, at the same time, preventing over-exertion and laryngeal fatigue.

From the speech standpoint, the larynx functions simply as a sound producer. Any complex sound put into the mouth and related cavities can be articulated into speech. It follows that, with the removal of the larynx, speech would be possible if another sound were introduced into the mouth. There are three common substitute sounds generating mechanisms used by laryngectomees. One is the reed type of artificial larynx in which the reed element is activated by the exhaled air which passes through a

tube from the tracheostomy. The sound which is generated by the reed travels through another tube into the mouth, where it is articulated into speech. A second type of sound producer is the Electrolarynx, a battery operated buzzer which is placed against the neck in such a position that the vibrations activate the air in the pharynx, and the resulting sound is articulated in the customary manner. The third mechanism is a body structure which is trained to function as a pseudoglottis. This is a constriction capable of vibrating and is usually located at the junction of the esophagus and pharynx, and may occur higher in the pharynx or in the mouth. The air is customarily taken into the esophagus and expelled as in eructation, and is, therefore, called "esophageal speech." The skillful esophageal speaker presents an entirely normal appearance, his speaking is fluent, he can often change the pitch of his voice, and, although there is always some hoarseness present, the quality of his voice is relatively normal. The laryngectomized usually prefer esophageal speech, not only because it is the most nearly normal procedure but because there are fewer esthetic problems, and also because the artificial devices occasionally fail to function or are not always within easy reach when needed.

ESOPHAGEAL SPEECH

There are several common methods employed in teaching esophageal speech. Each relates primarily to the way the phonatory air, as distinguished from respiratory air, is taken in. A few teachers claim superiority of one over another, but the majority of teachers adopt the procedures to the patient. Those who are most adamant about the "best" method are apt to be those laryngectomees who hold the opinion that the method which worked for them is the one everyone should use.

The two basic procedures for taking in the air are injection and inhalation. Neither of these is "swallowing" in the true sense; nevertheless, that term is often used in the literature. In the writer's opinion, swallowed air is rarely employed in speaking. Injection here means that the air in the mouth is compressed and forced into the esophagus, either by the upward and backward thrust of the tongue or by a modification of this movement combined with the tensing of the lips and cheeks. With the closure of the nasal port the only place where the compressed air can go is into the esophagus. The sound is produced by the immediate expulsion of the air.

The inhalation method uses the same basic principle as respiratory inhalation. The patient learns to

open the upper end of the esophagus at the moment of inhalation. The reduced pressure in the thorax which draws air into the lungs also draws the air from the mouth and pharynx into the esophagus. Each method has produced excellent speakers, which is reasonable evidence that no one method is necessarily the best.

It has been observed that esophageal speech is learned more quickly when the individual accepts his problem easily and is willing to try to learn. Those who are greatly depressed by the surgery or those who have little need for talking are ordinarily the slowest in regaining their speech.

It has been found, also, that the rate of learning and the excellence of the results obtained are not directly related to the type of surgery performed.¹ Certain persons have developed excellent speech following each of the usual procedures, such as narrow field, wide field, with their modifications, and radical neck resections.

NERVE PARALYSIS AFTER SURGERY

The fourth type of voice defect which should be mentioned here as a postsurgery problem is that which results from paralysis. It is an observed fact that thyroidectomy and some other neck surgery often result unavoidably in damage to one or both of the recurrent laryngeal nerves. The voices of these patients vary from a whisper to relatively normal sound production. The nearly normal voices usually accompany abductor paralysis, since the cords are in, or can be placed in, approximation. The opposite, or adductor, paralysis produces the greater voice problems because there is extensive air wastage and little vibration of the cords.

Voice rehabilitation in cases of paralysis is based fundamentally on the discovery of the patient's potential compensatory or substitute sound producers, and his guidance in their use. With bilateral adductor paralysis the superior laryngeal structures can sometimes be approximated sufficiently to produce some sound. The other alternative is to teach esophageal speech.

With unilateral involvement the unaffected cord often develops the capacity to cross over beyond the midline far enough to approximate the paralyzed one. This condition is similar to that found following the surgical removal of one cord, which was mentioned earlier. The objective here, as well as in other laryngeal conditions which require compensatory procedures, is to keep the person practicing

without excessive strain or fatigue, and without discouragement.

RESONANCE PROBLEM

Nothing has been said as yet about the resonance problems which result from surgery. Of the several, there is one which is particularly pertinent to this discussion and which should be mentioned. This is the hypernasality which sometimes follows adenoidectomy. It is quite handicapping, and in some instances can be avoided.

Some children use the adenoid tissue in forming the velopharyngeal closure. A few of these seem to have an unusually deep pharynx, i.e., from front to back. When the adenoid tissue is removed they have essentially the same condition as in a congenitally short palate. These are most unfortunate cases, and are difficult to correct either by surgery or training. Such a person is unable to close off the nasopharynx, with the result that the sound escapes through the nose.

The other children who use the adenoid tissue in the velopharyngeal closure appear to have normal structures. It seems that these have developed the habit of limited muscular contraction because the adenoid mass made the greater movement unnecessary. Where this assumption is correct, these children will respond to training, and the speech will improve gradually. To avoid the occasional irreparable damage it seems justified to urge great caution and conservatism in the removal of adenoid tissue.

Exercises, both direct and indirect, for increasing the closure are effective. The direct work includes massage of the palate, stimulation of the gag reflex, etc. Some of the indirect exercises are: drinking sips of water, blowing various toys, and speech drills emphasizing non-nasal sounds with wide mouth openings and vigorous mandibular movements. These seem to activate the whole oral mechanism, including the velopharyngeal closure. Usually the prognosis for establishing normal resonance in these cases is favorable.

(When this paper was presented, it was followed by an illustrative motion picture which showed both normal and abnormal laryngeal structure and function.)

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HAVE YOU A BACKACHE?

CHARLES WEER GOFF, M.D., *Hartford*

DOES your patient have a backache? If not today he will likely have one tomorrow, because his chances are multiple. Man is an erect walking, erect sitting biological unit, composed of systems that have not adapted well enough to date to withstand the multitudinous stresses and strains of our lifetime. Backache is a symptom and not a cause. To relieve the simple type of backache, which usually comes from poor posture combined with fatigue, often is a simple matter. To prevent a backache is even more commendable.

For many years the author has been following a system of positioning and exercises which has been effective in relieving, and often in preventing, recurrent attacks of simple backache. If these are presented to patients in a form that is attractive, their cooperation is apt to be proportional. Rehabilitation, following abdominal and neurological surgery and, of course, after orthopedic surgery, is likewise hastened by these recommendations and exercises. Kraus and Hirschland¹ have recommended similar procedures for school children with postural disorders. They are also used as muscular fitness tests.

HOW TO STAND; TO SIT; TO REST IN BED AND TO RELAX IN GENERAL

Frequent assumption of a good position in the erect standing, sitting or sleeping stance is the most important rule. Just to do exercises will accomplish a good deal but not enough unless the exercises are accompanied by consistently assuming good postural positions. Then it grows into a good habit. Exercises should also aim to correct defects in the assumption of a bodily position and to strengthen muscles that will aid and maintain these corrected postures. The use of braces, belts, corsets and other mechanical supports may be used toward obtaining more quickly the proper body postures and, thus, to relieve on a temporary basis strains of the various structures of the shoulders, back and abdomen. They should be discarded at as early a moment as possible. Continuous brace wearing actually

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SUMMARY

The relief of backache, usually the result of poor posture plus fatigue, is often simple while the prevention of backache is even more commendable. A system of positioning and exercises is outlined to be followed in relieving and often in preventing backache. Drawings are furnished to illustrate the text.

weakens the muscles of posture. These should be considered only in those instances where the physician believes the backache is of long standing, and then selectively.

STANDING

No one should assume this position for long. It is extremely tiring. Shifting the weight to one foot, while placing the other slightly forward, and bending its knee is a more easily maintained erect stance. This is called by the French the "hanchée" and is the favorite position understood by and portrayed by many ancient classical Greek sculptors. It is maintained by a minimal muscular effort, the ligaments assuming most of the strain. The position of a soldier "at attention" is not permissible except under military circumstances. Everyone has seen men faint on parade from sheer fatigue.

To acquire the best standing posture in each individual case, the person should first stand against the flat wall with the heels, buttocks, upper back and head all touching the hard surface. Then, by shifting the feet forward some 4 inches and slumping moderately, so that the lumbar curve is reduced and the lower two-thirds of the back up to the shoulder blades are in flat contact with the wall, the weight can be brought forward over the feet, still assuming the same relaxed stance. This is not a "pretty" posture from the esthetic or military standpoint, but it is a relaxed attitude for the entire body. Head should be up, eyes straight ahead and on the

level, chin drawn slightly back, and the pelvis rolled upward and forward. Practice makes this easy. The feet may be separated about 3 inches or more for added comfort and toed outwardly moderately. A few deep breaths will help relaxation. Never mind the abdomen. This will take a good position if the muscles are strong enough. If not, they will become stronger after the exercising as recommended in the next section.

SITTING

Chairs and seats are usually a standard height and too high for short statured people. These individuals cannot relax well in ordinary chairs. They should select lower seats. The buttocks should be well back on the seat surface and the entire support should make contact with the individual's back, up to the shoulder blade, at which point a forward slump, moderate not great, is more comfortable. Chairs should have the lower portion of their backs cut away to allow for the bulge of the buttocks, or should be shaped to conform with the average back. Hands may be resting on the chair arms or in the lap. The important element consists of an additional flattening of the lumbar spine while sitting. Soft back cushions are aids in permitting body conformation. The commercial plane seat is an excellent example of a well engineered chair and is remarkably comfortable. Its adjustable back adds to the aids useful in obtaining relaxation while sitting. Feet can be flat on the floor or raised on a soft surfaced stool, as high as the front edge of the chair. Automobile seats need to be fairly close to the steering wheel and high enough for good visibility. Crossing the knees is relaxing for a short time only. Stretching out the lower extremities often is a relief.

LYING

Resting on a bed, flat table or floor, removes the gravitational effects to such a degree that all the chest and abdominal viscera, the columns of blood within the arms and legs and the brain are all relieved. Congestion is reduced and all strain on postural structures is removed. Relaxation naturally follows. Further relaxation is achieved with a few aids.

BEGINNERS POSITION

A small pillow is placed under the back of the chest when lying on the back, and two larger pillows are placed under the knees. This is the maintained position when attempting to go to sleep. Some will remain in this position, but the restless sleeper will

shift out of it. Nevertheless, it accomplishes some good while maintained. One average pillow can be used under the head.

SECOND POSITION

After a few days, the pillow is removed from under the chest, and this pillow, together with one other pillow, constituting a total of four, are placed under the knees. Now, the low back is flattened completely. Before falling asleep the hands should be placed over and under the head for a short time. One should not fall asleep with the hands over the head. By so positioning the upper extremities, the thorax or chest is elevated and all of the structures are allowed to drop back into a more normal position.

FACE DOWN POSITION

If it should ever be necessary to lie prone, 3 pillows should be placed under the abdomen, none under the head, other than a very small one to soften pressure on the face. The head should never be turned very much to one side or the other but one arm should be placed under the side of the head to support it easily. This position should be assumed only when an aide is applying heat to the back, massaging the back, or to relieve any pressure on the buttock or low back.

These three positions are essential for relaxation, useful to everyone over 30 years of age, and especially for those who suffer from backaches. The latter position should not be used for sleeping. Never fall asleep on the face.

EXERCISES TO ACHIEVE MUSCULAR FITNESS AND RELAXATION, TO BE DONE DAILY—10 TIMES EACH

EXERCISE 1

Purpose: To strengthen the upper and lower abdominals as well as the psoas muscles.

Position: Lying on back, hands clasped behind neck, feet held down on the table or floor or placed under a heavy piece of furniture as resistance. Keep your hands behind your neck and try to roll up into a sitting position.

EXERCISE 2

Purpose: To strengthen abdominals alone.

Position: Same position, hands behind neck, knees bent, feet held down on the table or floor. Keep your hands behind your neck and try to roll up into a sitting position as before.

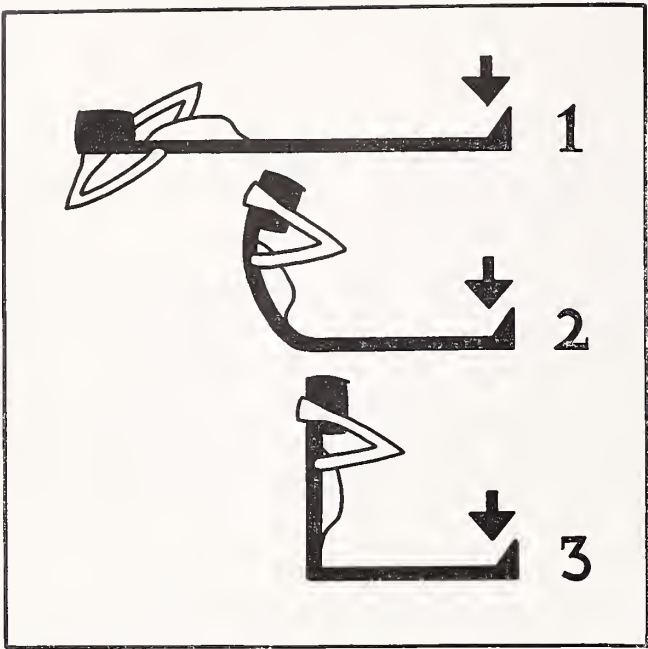


Figure 1, Exercise 1

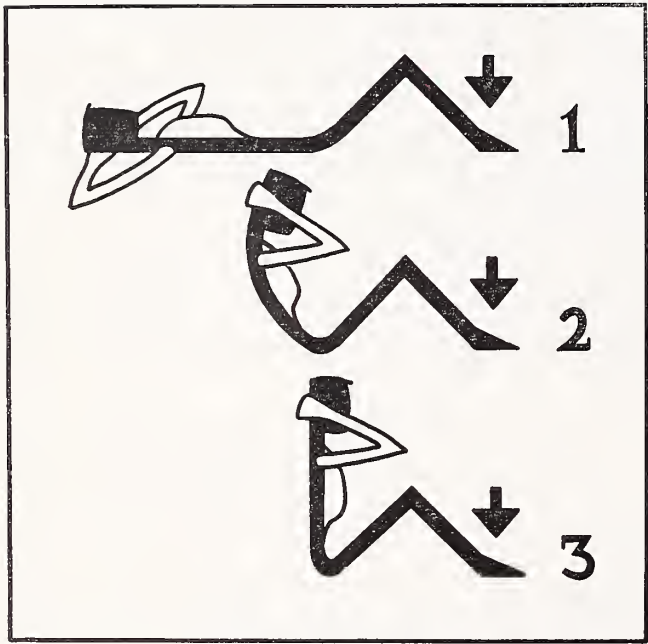


Figure 2, Exercise 2

EXERCISE 3

Purpose: To strengthen the psoas and lower abdominals.

Position: Same position with hands behind neck, the legs extended. Keep your knees straight and lift your feet ten inches off of the table. Keep them there for a count of ten seconds.

EXERCISE 4

Purpose: To strengthen the upper back muscles.

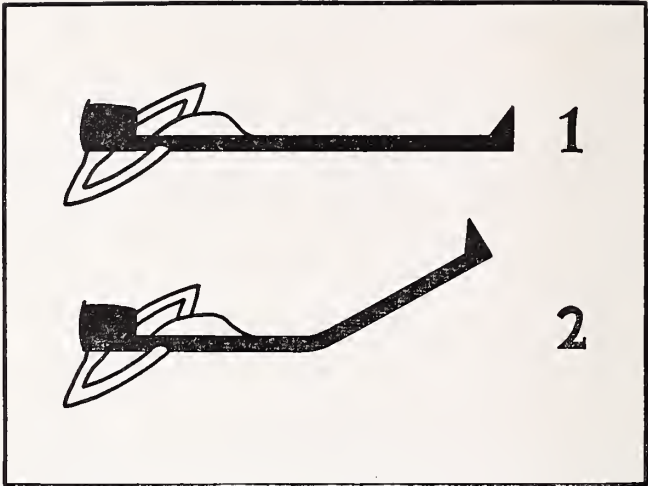


Figure 3, Exercise 3.

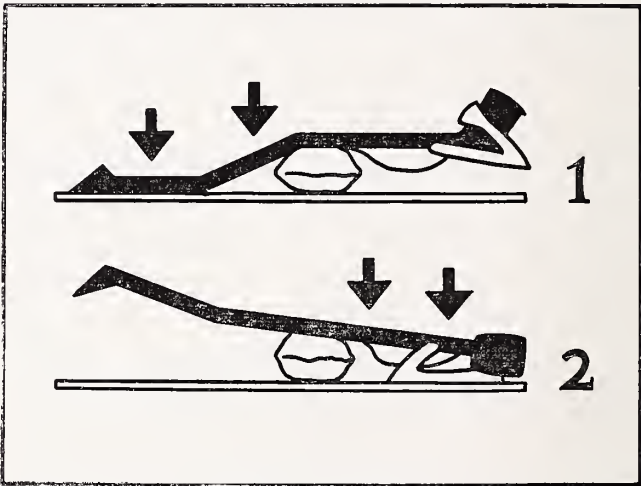


Figure 4, Exercise 4

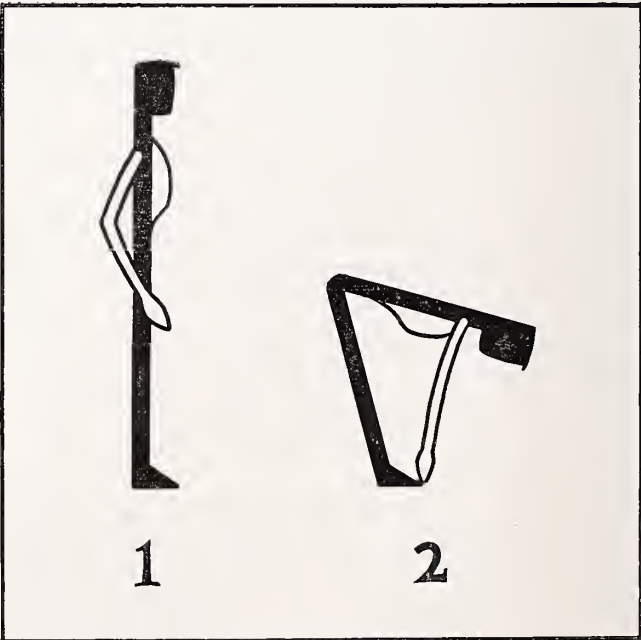


Figure 5, Exercise 5

Position: Lying on face with a pillow under abdomen (be sure the pillow is large enough), but far enough down to give the body the feeling of being a seesaw which, if weighted at one end, the other end would be able to be held in the air. Then rock back and forth slowly. Roll over onto your side, after exercising, and lift up the middle, so that you can easily slide the pillow from under you.

EXERCISE 5

Purpose: To stretch the back and hamstring muscles.

Position: Standing erect in stocking or bare feet, hands at sides. Put your feet together, keep your

knees straight and lean down slowly and see how close you can come to touching the floor with your finger tips. Stay down as far as you can for a count of three. Do not strain but relax at the end of the stretch.

A final word of caution is applicable only in those instances where intractable pain in the low back becomes evident. Accurate diagnostic procedures will then bring to light additional factors of casualty that are only amenable when greater measures are instituted. These should be undertaken.

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HOSPITAL ADMISSION X-RAYS

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MASS chest radiography of general population groups has indicated a steady decline in the incidence of tuberculosis. The statistics for Connecticut furnish an example: from 1945-1953 the percentage case find has dropped from 1.67 to 0.61. This outcome has stimulated a search for more effective ways to utilize mass x-ray screening technique.

Present analyses of x-ray survey statistics suggest a higher tuberculosis case find among older age groups, especially males, and among hospital admissions. This paper is devoted to a consideration of the advantages of routine chest radiography of all hospital admissions, both inpatients and outpatients.

The benefits of x-raying all hospital admissions are not limited solely to a higher tuberculosis case find: the amount of cardiac and nontuberculous pulmonary disease discovered would alone warrant serious consideration of this procedure.

The mortality from bronchogenic carcinoma in recent years has increased more rapidly than that from any other form of cancer. There is general agreement that this and other neoplasms in the chest occur in larger numbers each year, that the increase is real and not only a result of better diagnosis. Meanwhile larger numbers of people have been examined for chest diseases.

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SUMMARY

Attention is called to the benefits derived from taking x-rays on all hospital admissions. Coupled with this admission x-ray should be a thorough follow-up. Reports from hospitals which perform admission chest x-rays are cited and methods to reduce the cost suggested. These include both outpatient and inpatient.

It has been estimated* that if the incidence of cancer of this type continues to increase, more than 47,000 persons in this country will have lung cancer in 1970. The part played by tobacco smoking has been considered at some length. Although there is less than complete agreement on this particular subject, one result is an increased interest by many persons in obtaining chest x-rays.

IMPORTANCE OF ROUTINE X-RAY PROGRAMS

The routine use of chest x-rays for all patients entering clinics and hospitals, as a service compar-

*Alton Ochsner, *Postgrad. Med.* 13:214, March 1953

able to the routine blood Wasserman test, has been advised by the American Hospital Association, in cooperation with the USPHS and the National Tuberculosis Association.

The president of the N.T.A., W. P. Shephard, in 1946 stated—"Routine chest x-rays of all hospital admissions is a feasible and practical procedure. No well run hospital would admit a case of typhoid fever without instituting proper isolation. Today, tuberculosis is more common than typhoid fever. It is more elusive, often unrecognized and contagious. Admitted unknowingly, it is a menace to the patient, hospital personnel, other patients and the public. Admitted knowingly, it is easy to isolate, the patient's proper care is assured and the public is protected."

IMPORTANCE OF FOLLOW-UP

The value of the x-ray program will be in proportion to the thoroughness of follow-up on all suspects, contacts, and cases. The suspects and the contacts must be screened to find the cases. The cases must be isolated and treated. The entire program should be integrated with other existing control programs in the community.

DISCUSSION OF LITERATURE

Although the value of x-raying all hospital admissions has been recognized for many years, a relatively small group of hospitals have any such program at all, and it is generally accepted that even when the program is in effect there are weak links in the chain from original x-ray to final diagnosis and disposition of the cases found. In 1948, of 4,539 hospitals in U. S. A. surveyed, only 247, or a little more than 5 per cent, reported that chest x-rays were made on all admissions. (The Management of Tuberculosis in General Hospitals; Chicago, 1946.) (NTA transactions 1952.) For the past 14 years statistical reports on chest surveys on hospital admissions have become more frequent. These reports consistently indicate that 2 to 4 per cent of those x-rayed show evidence of re-infection tuberculosis and 10 to 12 per cent show evidence of pulmonary pathology. The enormous value of these findings to the community, the patient, and the hospital administration and personnel is unquestioned. (Case Finding Potential, R. B. Turnbull, M.D., N.T.A. Proceedings, 1952.)

In 1936 a report on chest x-rays done on 1,101 admissions to the University of Michigan Hospital by F. J. Hodges indicated that x-ray evidence of intrathoracic lesions was present in 90 (8.1 per cent)

of the patients examined. In the same year Pohie and Oatway x-rayed the chests of 1,460 patients admitted to the hospital with no abnormal findings in their chests on physical examination. Roentgen evidence of pulmonary tuberculosis was found in 34 (or 2.3 per cent). In 1940 Dr. Plunkett and Mr. Mikol reported on 4,853 patients admitted to 14 general hospitals. Of these 128 (or 2.6 per cent) had x-ray signs of secondary tuberculosis. By 1941 improvement in the photofluorographic apparatus and techniques allowed more widespread use of the chest x-ray as a screening procedure and Douglas and Berkelo reported 29 cases (0.61 per cent) of active tuberculosis among 4,727 expectant mothers examined.

F. J. Hodges followed up his original report with further work in 1942. Using the photoroentgen x-ray apparatus, he reported abnormalities present in the chest films of 732 (9.3 per cent) patients among the 7,841 admissions to general hospitals who were examined. Turning their attention to hospital personnel, Hanser and Dundon reported in 1945 that 21 persons (2.1 per cent) of 1,000 asymptomatic hospital employees had evidence of minimal tuberculosis. They used both 4" by 5" and 14" by 17" films in this study.

By 1949 the technique and follow-up procedure had improved to the point that Boucot and her group could report on 8,992 individuals x-rayed at the photofluorographic station in Philadelphia, combining this with a study of admissions to four hospitals in the area. There were 1,257 x-rays which were interpreted as showing abnormal findings. Further study on 416 patients confirmed the original impression in 290, while the diagnosis was not confirmed or was changed in 126 patients.

COSTS AS REPORTED IN THE LITERATURE

To keep down the costs of special equipment, one plan suggested was based on the use of x-ray equipment already in operation in the hospital with additional provision for camera, hood, stand and installation, etc. However, in July 1951 Siegel, Plunkett and Hilleboe of the New York State Department of Health reported that adding photofluorographic accessories to existing radiographic equipment did not work well in New York, because of interference with routine x-ray department activities.

An alternative and preferred plan is to provide a fully automatic photoroentgen unit, with dark room accessories, and adequate floor space of about 500

square feet. The cost of such an installation in recent months has amounted to about \$12,000. The cost of the part- or full-time services of clerk, technician and roentgenologist does vary, of course, with the size of the hospital, numbers of admission chest x-rays made and similar factors.

In one Connecticut hospital where a separate photoroentgen unit was recently installed, the hospital administrator after careful cost accounting estimated that, in an average year with about 4,000 routine 4" x 5" films, the cost with no charge for interpretation would be approximately \$0.30 per examination.

EXPERIENCE TO DATE IN CONNECTICUT

In order to learn the extent to which routine chest x-rays are made on hospital patients in Connecticut, a questionnaire was sent to the director or administrator of the various general hospitals in the State. Thirty-six replies were received from the 54 general hospitals to whom the questionnaire was sent.

The following table of hospitals, divided (A) according to bed capacity, shows in column B the numbers of hospitals of each size where routine chest admission x-rays are made, and in column C the numbers of hospitals where these tests are not done routinely.

Later the ten hospitals where routine admission chest x-rays are made were visited and various staff members interviewed. The discussion included a number of confidential subjects and provided more

TABLE I

A	B	C	
		X-RAYS	
	ADMISSION	NOT MADE	
HOSPITAL SIZE	X-RAYS MADE	ROUTINELY	TOTAL
Under 100 beds.....	2	12	14
100 to 199 beds.....	1	7	8
200 to 299 beds.....	3	4	7
300 to 399 beds.....	2	2	4
400 beds and over.....	2	1	3
	—	—	—
Total	10	26	36

detailed and more accurate data than available by correspondence.

The following table summarizes our findings. The first column lists the institutions numerically from 1 to 10 according to size. The second and third column record, respectively, the average daily census and the number of chest x-rays made in a recent calendar year. The other columns are self explanatory.

X-RAY EQUIPMENT

In two of the ten hospitals studied, where the annual numbers of admissions are small, 14" x 17" conventional chest x-rays are made using the regular hospital equipment. In eight hospitals, photoroentgen units are in use, generally as accessories to equipment already functioning for other purposes.

In five hospitals, film in the 4" x 5" size is used to make stereos. In three hospitals where the units

TABLE II

HOSPITAL	AVERAGE DAILY CENSUS	CHEST FILMS PER YEAR	SIZE OF FILM, ETC.	TYPE OF EQUIPMENT	AGE GROUPS EXAMINED
1	27	1217	14" x 17"	reg.	all patients
2	96	not stated	4" x 5"	spec.	all patients
3	159	5976	4" x 5" stereo	spec.	all patients
4	222	4975	70 mm. pack film	spec.	all patients
5	287	6905	4" x 5" stereo	spec.	6 years and over
6	288	2802	14" x 17"	reg.	all patients
7	313	5623	4" x 5" stereo	spec.	8 years and over
8	350	5129	70 mm. PA & LAT	spec.	6 years and over
9	381	5744	70 mm.	spec.	6 years and over
10	602	8500	4" x 5" stereo	spec.	all patients

were installed at earlier dates, 70 mm. film is used, and in one instance a 70 mm. lateral was also made.

LAYOUT

In five of the eight hospitals using photoroentgen equipment, the unit is located on the first or ground floor. Here it is on the same level as the admitting office for inpatient and the registration desk for outpatients. In one hospital that was recently renovated and enlarged, the unit is efficiently located where it also serves a third function, without interference of one by another. This hospital offers mass chest x-rays of industrial groups brought by buses or autos to the hospital from the plants.

OPERATORS

In most hospitals one technician is responsible for making the chest films, and other workers help when needed during vacation periods, holidays, etc. In one large hospital a registered nurse technician is assigned to the program. She is a graduate who has had experience as a charge nurse in other departments of the hospital. She also has had training in general x-ray techniques and considerable experience in dark room work. She operates the Mass X-ray Unit, develops the films and expedites the program in many ways, such as effecting the recall of patients admitted without x-ray at night or over the weekends.

HOURS OF OPERATION

Admission chest x-rays are made on week days in most of the ten hospitals during the usual office hours of 8:00 A. M. to 5:00 P. M., except Saturday in one instance. In two hospitals the program is continued during the evening and in one hospital on Sunday afternoons also.

As yet the recommended optimum of admission x-ray service on the basis of a 24 hour day and 7 day week has not been provided in any of the ten hospitals.

POPULATION X-RAYED: INPATIENTS

In six hospitals efforts are made to x-ray all patients admitted, except persons with recent negative chest x-rays (from one to twelve months prior to admission). Children under eight years of age are omitted in one hospital and those under six years in three other hospitals. These children are tuberculin tested routinely. In most hospitals small admission films are not made on patients who are sent in for investigation and treatment of suspected or known cardiac

or pulmonary or other chest conditions requiring conventional x-rays. In most hospitals patients are not x-rayed if admitted for T. and A. only. Most patients for elective surgery generally receive chest x-rays. In some hospitals the report and the developed films are sent with the patient to the operating room. In one hospital where new cases of active pulmonary tuberculosis occurred recently in members of the staff in the department of anesthesia, the patient's record is carefully checked for a report of a negative chest before starting anesthesia.

POPULATION X-RAYED: OUTPATIENTS

Outpatient clinics, including prenatal services, are conducted in most hospitals. Most obstetrical service patients are sent for chest x-rays in the second or third trimester. This practice is well established even in the hospitals that do not have extensive outpatient clinics, nor attempt to x-ray every registered outpatient.

In four hospitals, the obstetrical patients are pre-registered when they visit the hospital for Rh and other lab tests, including chest films which later serve as hospital admission x-rays when the patients enter the maternity department.

HOSPITAL PERSONNEL EXAMINED

The photofluorographic equipment and mass x-ray units are used in most hospitals to make pre-employment and periodic chest x-rays of the hospital workers, especially student and bedside nurses, interns and laboratory workers.

In one hospital, personnel in contact with patients having tuberculosis, including persons administering anesthesia and persons making laboratory tests on sputum or other materials, are re-x-rayed at intervals of three months. Personnel in contact with general hospital patients in most of the hospitals are re-x-rayed every six months. Employees with less significant contact, including food handlers and others in the dietary department, receive chest x-rays at start of employment and thereafter annually. A tickler file has proved useful as a check on periodic re-x-raying. A file card is entered for each hospital employee and these are grouped alphabetically according to the month in which the next x-ray is due.

STATISTICAL REPORT FOR A CALENDAR YEAR

IN ONE HOSPITAL

In one hospital in Connecticut the records for a recent calendar year showed that a total of 2,802

admission chest x-rays were made. Of these 2,355 were interpreted as negative.

Pathological conditions other than tuberculosis were found in 318 of the 447 total positives. Pleuritis was noted in 96 of these positive x-rays. The remaining 33 positive films included one of suspected tuberculosis and 32 of pulmonary tuberculosis.

The 32 newly discovered cases were further divided into seven active and 25 inactive cases. The seven active cases included three minimal and four moderately advanced. There were twenty-three minimal and two moderately advanced patients in the group of twenty-five inactive cases. The total of 32 patients thus was composed of 26 minimal, 6 moderately, and no far advanced cases.

Statistically the 2802 x-ray examinations showed 32 new cases, that is a case rate of 1.1 per cent or 11 per 1,000.

STATISTICAL REPORT OF 10,000 MINIFILMS

At one large Connecticut hospital, after the program of routine admission chest x-rays had been in use for a sufficient time, a study was made of the findings in 10,000 miniature film examinations.

The largest group, numbering 9,384, were negative. Another group of 125 films was classed as essentially negative, showing findings of little significance such as azygos lobes or cervical ribs.

In 218 instances diagnosis was reserved. In another large group of 337 chest films, there were abnormal findings other than tuberculosis. These included 70 cases of cardiovascular lesions, (0.7 per cent), and 8 cases of malignancy.

Another group of 93 films (0.93 per cent) was read as showing evidence of tuberculosis, with further study indicated. In 50 cases in this group the x-ray impression was of probably inactive lesions.

While emphasis has always been placed on finding the active cases of tuberculosis in the community, Paul D. Crimm in 1952 pointed out that the so-called inactive case is also important and should be reported and followed. His report included an

analysis of 70,877 x-rays with 4 x 10 inch minifilms. Re-infection types of tuberculosis were discovered in 4 per cent (2,910), including 2,866 inactive (as presumed by x-ray alone) and 44 or 0.06 per cent of active cases. Many other types of pathology and abnormalities were also noted. In his discussion of these findings, Crimm states "an adequate roentgen-ray program must not only find the active case, but it must locate as far as possible the inactive cases who may later develop into active cases of tuberculosis. Many minimal cases of tuberculosis heal and later break down without knowledge of its previous existence. This group of inactive cases accounts for the large number of moderately advanced and far advanced cases which reside in our sanatoriums. We will never diminish the group of far advanced cases unless we locate them in the inactive minimal stage, as well as the active minimal stage."

CONCLUSIONS

Protection of all patients and of personnel is the primary purpose of these procedures.

Hospital routine admission chest x-ray programs have found from two to ten times more cases of previously unknown tuberculosis than x-ray surveys in the community at large.

With a minimum of inconvenience or expense to the patient or personnel, a single chest x-ray as a screening test has been found to show more previously unsuspected disease than routine laboratory tests.

Control of compensation costs to the hospital has also been claimed.

Cardiovascular disease, cancer and other critical chest conditions other than tuberculosis, such as pneumonia, lung abscess, etc., have been reported, as well as cystic disease, foreign body and other less frequent findings.

These programs may be integrated with other community facilities and organizations for the ultimate good of the patient, the hospital and the community.

CURRENT PROBLEMS IN MEDICAL EDUCATION

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PHYSICIANS actively engaged in the practice of medicine are likely to think of medical education in terms of their own four years of student experience in medical school. So, at the beginning of this paper, the much greater breadth of modern medical education should be emphasized. Besides being deeply concerned with the preliminary and subsequent training essential to the effectiveness of the four years of medical school as specific preparation for the practice of medicine, present day medical education is vitally interested in the fundamental discoveries that advance medical knowledge. Obviously, too, it covers the application of these discoveries to the care of patients. Thus, in addition to teaching undergraduate medical students and actually doing both pure and applied research, the medical school faculty has the important function of training the investigators and teachers of the future. It is also wholly responsible for the instruction of interns, residents and visiting fellows, and of trainees and graduate students in the various specialties and in the basic medical sciences. Moreover, the faculty shares in the teaching of dentists, nurses, physical and occupational therapists, x-ray and laboratory technicians, public health students, and pharmacists, and it participates in postgraduate courses for practicing physicians. As numerical indication of the extent of these extra teaching obligations, in 1952-53 there were 27,688 undergraduate medical students in the United States, while a total of 54,149 other students also received instruction from medical schools¹ (Table I).

Thus, it is readily apparent that medical education occupies a key position in the whole structure of medicine. The manifold, grave obligations imposed by this critical position are also obvious. It is the

purpose of this paper to discuss some of the more important problems that medical education must face at this midpoint of the century.

THE FACULTY

The value of an educational system is determined by the caliber of the men who conduct it. The medical profession has always attracted men of high purpose, good intellect and scientific attainment, and most of the great leaders in medicine have also been engaged in medical education. This statement still holds, but never before today have so many things combined to offer such strong competition to medical schools for the services of young scientists. The economic advantages of private practice, well paid positions in industry, and the demands of governmental and private research institutes have been draining the able younger men from the basic science departments of teaching institutions at a rate that foretakens disaster. The needs of the Armed Forces for personnel produce another serious drain. There has been a lamentable lack of appreciation on the part of many local draft boards of the importance of maintaining medical school faculties and in many States the mediation of advisory committees has not been effective in combating this attitude. Since the medical schools are training grounds for officers of the Armed Forces in just as true a sense as are the military schools, their faculties too must remain intact if we are to continue to produce adequately trained physicians to care for both the civilian population and the Armed Forces. It is a relief however to be able to report that there is far wider appreciation of the seriousness of the faculty recruitment problem than was true a few years ago, and that although there is as yet no over-all satisfactory solution, corrective steps have been taken by the medical schools themselves, by governmental agencies, and by certain foundations. It is to be hoped that lessened demands of the Armed Forces,

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better informed draft boards, and better functioning state advisory committees to Selective Service may virtually stop losses from that source.

Less well understood is the fact that the clinical departments within the medical schools themselves have also drawn away basic science department personnel. As programs in fundamental research developed in clinical departments, competition with basic science departments for able recent graduates to conduct this research resulted, and because the clinical departments frequently could offer more money, readier clinical contacts and less teaching load, they have all too frequently been successful in this competition. Perhaps the only true solution to this problem lies in the ability to retain enough qualified graduates to fill the needs of both groups.

TABLE I

The number of students, other than undergraduates in medical schools, for part of whose instruction medical schools are responsible, is surprisingly large:

CLASSIFICATION OF STUDENT	NUMBER
Dental students	4,169
Nursing	10,989
Pharmacy	1,667
Technicians	2,958
Non-medical in medical courses.....	8,631
Physicians (refresher courses).....	14,491
Physicians (basic science).....	706
Fellows	1,240
Residents	4,546
Interns	1,898
Graduate (clinical)	2,285
Graduate (basic science).....	1,419
Special	140
Total	54,149

Modified from Medical Education in the U. S. and Canada. Manlove, F. R., Anderson, D. G., and Tipner, A., J. A. M. A. 153:2, Sept. 12, 1953.

THE STUDENT

After World War II applicants for admission to American medical schools suddenly increased to a number far in excess of that ever known before. This phenomenon was produced by the dramatic medical and surgical successes of recent years, arousing great public interest in health, by the relatively good financial returns to physicians, by the backlog of students created by the war, and by generous government assistance to them through the "G. I. Bill." The peak was reached in 1949-50 with 24,434 individual applicants for 7,042 openings.² Anyone who

is at all familiar with the conduct of medical education will understand that it is not possible to expand the enrollment of students simply by adding a few more seats and desks and a few extra faculty members. In the first place, expansion of any extent is very costly. Even if an adequate number of new instructors and trained assistants should be available, and they were not then and are not now, it requires more laboratory space and equipment, and more animal quarters, changes often necessitating the construction of new buildings. In the clinical years it requires expansion of hospital facilities, more beds and more patients in those beds, more outpatient space and more outpatients, more conference rooms and amphitheatres; for American medical educational methods follow the early Greek concept, depending far more on experience than on book learning, on participation than on passive observation. Nevertheless, great efforts were correctly made throughout the country and the number of students admitted to first year classes mounted from 6,487 in 1947³ to 7,489 in 1953,⁴ or an increase of 15.4 per cent.

During these years, legislators and others became very much excited by the bitter disappointment of applicants not admitted to medical schools, and in many States legislation was enacted that provided for the opening of new schools or for enrollments greater than established schools could absorb properly. Also in order to appease constituents, many States placed restrictions on the acceptance of residents of other States. The result has been an inequitable selection of students from a standpoint of scholastic ability and excellence of preliminary training, for many of the schools in less populous States or those in which there was less interest in medical education have had scarcely enough students to fill their classes, while other schools with no admission restrictions have had a superfluity of well qualified candidates. Meanwhile, for easily predictable reasons, the number of applicants has been falling steadily each year, declining from 24,434 in 1949 to 14,678 in 1953, or from the standpoint of ratio of acceptances to applicants of 1:3.5 down to 1:1.9 in the latter year (Table II). The causes for this decline are not hard to find; loss of the backlog created by the war, virtual elimination of veterans' financial assistance, increased demands of the Armed Forces, and, more than all of these, the low birth rate during the "depression" years. The smaller number of children born in those years who are now coming of age for medical school will

probably continue to affect the number of applicants for some years to come.

The ratio of applicants to those accepted is a matter that could create a serious problem. The well advertised prediction that there will be a gross shortage of physicians in 1960 has contributed to bringing about a very considerable increase in the number and size of medical schools, effective just as the demand for enrollment is showing a gross decline. If this double-edged process continues, we may well find schools with elaborate and expensive plants and faculties and a dearth of qualified candidates, inevitably followed first by a scramble on the part of the schools for students, then by the acceptance of students with fewer years of college preparation. The end result might well be a general lowering of scholastic standards.

Meanwhile, how certain are we that there will be any shortage of physicians in 1960? Qualified statisticians are completely divided on this question. Three facts stand out. First, the ratio of the number of people per physician is steadily falling. Second, more and more medical care is concentrated in hospitals and clinics, systems of communication and transportation are constantly improving, doctor and patient can come together more quickly and more easily with ensuing greater coverage per physician. Third, the estimates of the number of physicians on which this prediction was based ignored the large number of graduates of foreign medical schools who are immigrating to this country. This factor will be discussed later.

TABLE II

The number of applicants for admission to medical schools is decreasing while the number admitted is increasing:

YEAR	NUMBER OF	NUMBER	RATIO ADMITTED
ADMITTED	APPLICANTS	ADMITTED	TO APPLIED
1947	18,829	6,487	1:2.9
1948	24,242	6,688	1:3.6
1949	24,434	7,042	1:3.5
1950	22,279	7,177	1:3.1
1951	19,920	7,436	1:2.7
1952	16,763	7,425	1:2.2
1953	14,678	7,489	1:1.96

Source: Figures quoted from references "2," "3," and "4."

FINANCES

The student of today comes to medical school far better prepared to meet the challenge of medical education than has ever been true in the past; and he leaves medical school better equipped to meet the challenge of further training and practice than ever before. These great gains have been priced high. To the medical student there is the cost of added years of education before admission, of more years of graduate training, of the postponement of financially compensated work, of the delay of marriage and family or of its maintenance for a number of years at an economic level below that generally achieved by unskilled labor. To the medical schools there has been the cost of new buildings, more equipment, larger faculties. Education of our present high quality can be obtained only through expenditures far greater than those formerly available to medical

TABLE III

The number of aliens serving as first year interns and residents in hospitals in the United States has more than doubled since 1950:

YEAR		INTERNS		RESIDENTS		TOTAL	
		NUMBER	PER CENT	NUMBER	PER CENT	NUMBER	PER CENT
1950-51	Total	6,237		18,205		24,442	
	Non-citizen	722	11.6	1,350	7.4	2,072	8.5
1951-52	Total	6,783		16,135		22,918	
	Non-citizen	1,116	16.5	2,233	13.8	3,349	14.6
1952-53	Total	6,990		16,231		23,221	
	Non-citizen	1,353	19.4	3,035	18.7	4,388	18.9
1953-54	Total	7,705		18,191		25,896	
	Non-citizen	1,787	23.2	3,802	20.9	5,589	21.6

Source: Health Resources Advisory Committee, Office of Defense Mobilization.

Note: These figures include aliens who graduated from medical schools in the United States as well as those who received their degree from foreign medical schools.

schools. As a result, many private medical schools have become a great financial burden on their universities. State schools have by and large been in a better financial situation. It must be borne in mind that medical education as carried out in the United States today is expensive, that the community must be made aware of this and must be willing and able to support it. There are but few countries today that can support an educational program such as ours.

Tuition fees today pay for only a relatively small portion of the current operating cost of a medical school. This is a reversal of the situation in 1905, when medical schools generally paid a profit to those who controlled them, when this country had as many medical schools (160) as the rest of the world combined, when diploma mills flourished and when the quality of a large segment of American medical education sank to a very low level. Astonishing though it may seem, it is to 1905 that many spokesmen on the subject of physician shortage have pointed with great lamentation, proclaiming that in 1950 we graduated essentially the same number of physicians as in 1905. May we never witness a return to the conditions which prevailed then.

The financial plight of medical schools today is real, but there is also a more widespread realization of its seriousness, and, although the basic problem has not yet been solved, assistance is being received from many quarters. Research is now liberally financed from outside grants, although this, too, has brought its problems, one being that overhead payments do not match actual overhead costs and a secondary drain on general operating funds has thus been created. So-called training and teaching grants are available from both governmental and private sources, and more and more foundations are supporting pre- and postdoctoral fellows and career investigators. Just recently there has been belated recognition of the need to point this assistance toward the basic science departments.

State legislatures have become increasingly aware of the need to throw additional support to medical education and many of them have done so in liberal fashion. The question of the advisability of federal support has been argued strongly pro and con with no positive action and no final decision on the wisdom of this policy.

One of the most encouraging developments is an effort on the part of a number of private individuals through the National Fund for Medical Education to enlist the support of industry. While this effort

has not yet produced results of sufficient size to warrant great optimism, it is growing in size and strength. Physicians themselves, through the American Medical Education Foundation of the American Medical Association, have contributed an appreciable portion of the Fund.

There is one possible source of income for medical schools that might be developed more fully. Those States not now supporting a medical school could contribute through State appropriations to the support of private schools within their boundaries as is now done in Pennsylvania; or, if there are no schools in the State, could make a contribution on a per capita basis to outside schools accepting students from that State. A system similar to this has been in use in Florida.

One conclusion may be permissible at this point, that schools now in operation should be strengthened and supported more adequately before more new schools are opened.

THE CURRICULUM

The tremendous increase in the body of scientific knowledge and the development of medical specialties both have occurred in the first half of this century. The mass of new material to be mastered has made it imperative that the curriculum should not become an "overloaded ark." Specialization has tended to crowd from the scene the family physician and much that he represented in terms of close personal physician-patient relationship, especially the physician's understanding of his patients' emotional and family problems and his sympathetic attention to them. The gains of specialization have been many, the losses have not been insignificant.

Three major curricular changes have been designed to meet the problems thus created. First, basic science courses have been streamlined and better coordinated one with another. At the same time their correlation with clinical medicine has been improved. Second, there has been great improvement in clinical teaching through the use of blocks of time devoted to true clinical clerkships in the five basic clinical disciplines: medicine, surgery, obstetrics, pediatrics and psychiatry. Third, a number of schools have devised ways and means of stimulating in the student a broader understanding of the needs of the whole patient and of maintaining his interest in the patient as a person. While some opposition has been encountered to these latter efforts from certain individuals fearful that the student will be diverted from his interest in the scientific aspects of

medicine, experience has not borne out such forebodings. Most young men and women enter medicine because of their desire to help people by maintaining or restoring health. It is scarcely logical to believe that an increased understanding of, and interest in, people will diminish the medical students' appetite for the scientific knowledge by which they may enhance their ability to give aid. That the cultivation of that understanding and interest should be postponed until they enter practice seems equally illogical.

THE FOREIGN SCHOOL GRADUATE

Whereas in the early 1900's, physicians from all over the world who wanted to obtain the very best medical training available sought it in Europe, today a large proportion of them come to the United States and Canada. These foreign students of medicine should be, and are, welcomed with open arms; they all should, and many do, receive the best we have to offer. It is our clear duty to share our knowledge and our facilities with them to the benefit of world health, for it has been assumed that these physicians would return to their own countries to practice what they have learned, and in the past most of them have done so.

In a totally different category, however, is the truly large number of graduates of foreign medical schools who are now coming to the United States with no idea of returning to their own countries. These men are admitted on student or visitor visas with no screening whatever of their preliminary or medical educational qualifications, and a benevolent federal government makes it very easy for them to obtain permanent visas through a variety of means. At the moment the number of these graduates of foreign medical schools has swollen to a point that constitutes a real problem. While their presence has seemed to offer a ready alleviation of the discrepancy between the number of interns needed by our hospitals and the annual inadequate number of graduates of our own medical schools, this is proving to be an inexpedient solution, as will be shown. The recent great increase in the amount of hospital care has created a demand for resident house staff service that cannot be met in full by our own graduates, especially when their number is so greatly reduced by the fact that Selective Service has been permitting only one year of hospital training before induction into the Armed Forces. Little imagination is needed to picture the concern of the busy practi-

tioner when he finds that the hospital of which he is a staff member lacks an even remotely adequate number of interns. What could be more natural than for that hospital to enroll graduates of foreign schools, even though little or nothing is known of their readiness to assume an intern's responsibilities? It is high time that the members of such hospital staffs should realize what they are doing and should count the cost, for the cost is high.

Estimation of the gravity of this situation hinges upon the number of graduates of foreign schools involved, the adequacy or inadequacy of their basic medical education, and the effect of these two factors on the level of medical practice in this country. A few figures may be revealing.

In the intern residency year 1953-54 there were 1,787 aliens serving as first year interns in hospitals in the United States. This number represented 23.2 per cent of all interns. In addition in that same year, out of a total of 18,191 hospital residents in this country, 3,802 or 20.9 per cent were aliens (Table III). These figures include aliens who were graduates of medical schools in the United States, but they do not include American citizens who were graduates of foreign medical schools. Since the number of the latter group is with little question greater than the number of alien graduates of American schools, the significance of the figures as they apply to graduates of foreign medical schools now serving as hospital house staff officers in the United States, and who may subsequently desire to practice medicine in this country, is not altered. No one knows exactly how many of these physicians will return to their own countries, but one estimate, based on the small amount of available information, would indicate that about one-half of those serving in 1953-54 might presumptively be expected to do so. For proper assessment the composition of this group must be understood. We are not dealing now with those able professors and other well trained physicians who fled Nazi tyranny in the 1930's, but with a group whose education was received during and following the war years, at a time when the whole fabric of medical education in Europe and throughout much of the Far East had been torn asunder by death and dispersion of faculties, by bombing, burning and pillaging of hospitals and laboratories, with all of the disastrous consequences attendant upon invasion and occupation by Armed Forces of an enemy country. An age breakdown of foreign residents of 1953-54 shows about 43 per cent of them to be under 30

years of age, another 47 per cent to be between 30 and 39, and only 10 per cent to be over 40 years of age.

Our concept of what today constitutes a good medical education in the United States is so far above that which the economy of many of the countries exporting physicians to America can support, that a meaningful comparison between the two educational systems cannot be made. Preprofessional education in this country ordinarily requires 16 to 17 years, which is followed by 4 years of medical school. The usual course of preliminary education abroad requires 12 years, to which is added 6 years in medical education or a total of 18 years as against our 20 years. However, in many places only 10 years of education have preceded admission to medical school. Furthermore, there is no selective screening of students for such admission and the number of students in many of these schools, as compared with that to which we are accustomed in America, is extremely large. According to figures published by the World Health Organization⁵ in 1952-53 there were in those countries in Europe from which it was possible to obtain reports, four medical schools with over 5,000 students, fifteen schools with from 2,000 to 5,000 students, and nineteen other schools with over 1,000 students enrolled. One of these schools awarded degrees to over 1,000 students in that year. These figures should be compared with a total enrollment of 713 with 164 graduates in the largest school in this country. These numbers will show the complete impossibility of giving to even the best students the sort of basic training required of all medical students in the United States.

For the practice of medicine there is no substitute for a sound training in the fundamental medical sciences. Of course it is possible to take an individual with a smattering of knowledge of these subjects, and, by superimposing hospital experience, to teach him the motions and techniques of the care of the sick, but he can rarely be made into the kind of physician that we expect in America today, the kind that we are graduating from our medical schools. Also, since our own graduates naturally select those hospitals that offer the best internship and residency training, the graduates of foreign schools must take what is left. Hence their hospital training too is perforce relatively poorer. If the many unscreened graduates of foreign schools now training in our hospitals are permitted to practice in this country,

as has been pointed out by Rappleye,⁶ there will inevitably come to be two classes of physicians, and two classes of patients: those treated by graduates of our own schools, and those, or at least most of those, treated by graduates of foreign schools. The general level of medical practice throughout the country is bound to suffer; we will have allowed the reproduction of a situation similar to that in existence at the turn of the century, when the products of the diploma mills practiced alongside of the graduates of good medical schools.

In considering the graduates of foreign medical schools, it must of course be understood that we speak in generalities, that there are excellent medical schools in other countries and that the capability of many of the individual foreign graduates is often very high. America has always been a land of opportunity and we hope always will be. There is no desire to exclude the able, well-trained physician; he is more than welcome. However, it is our belief that the great majority of the physicians now coming to this country have through no fault of their own had grossly inadequate preparation. We have a strong obligation to see that the American people receive the best medical care and a further obligation to protect our own graduates who are paying so dearly for the long and arduous education that we demand.

There is no easy solution to this problem, but each of us has certain obligations. First, we must all understand that the problem exists, realize its extent, and see that other people know of it. We must assist our state boards of licensure to maintain strict educational standards. They and we must be on our guard against legislation and regulations granting internship and residency training privileges with no safeguards against inadequate medical education. We must see to it that the hospital on whose staff we serve does not accept for training physicians with inadequate and unverified medical school preparation. Also, on the other hand, we must not permit the accepted foreign physicians to be exploited as cheap labor. Those who will be returning to their own countries should have received the maximum educational benefit from their hospital experience with us. Those who intend to remain in this country will obviously seek to obtain a license at the conclusion of their hospital training. Inadequate basic schooling upon which is superimposed nothing more satisfactory than several years in a specialty hospital, such as one caring for psychiatric or tuber-

culous patients, is poor preparation indeed for the practice of modern medicine.

Any effort to accredit foreign medical schools, such as that which has been carried out so successfully in this country by the Council on Medical Education and Hospitals of the American Medical Association, would appear doomed to failure both by the enormity of the undertaking and the lack of a satisfactory basis for comparison. Therefore we are forced to rely on some form of evaluation of the individual.

The eventual handling of this troublesome problem lies within the province of the various state boards of licensure. However, the regulations of the boards are controlled in large measure by state laws and obviously the situation may get completely out of hand long before 48 different States can be expected to pass the needed legislation. Therefore, those hospitals that wish to utilize the services of foreign physicians must adopt some procedure by which they may assure themselves that these physicians have received and benefited by a medical education good enough to entitle them to participate in the care of American hospital patients at the level of responsibility granted to interns and residents in the hospitals in question. The following proposal is offered: That all graduates of foreign schools be required to pass satisfactorily a specifically designed preliminary test similar to Parts I and II of the examinations of the National Board of Medical Examiners before they are acceptable for internship or residency appointment in any hospital in the United States.

The evaluation of foreign medical credentials should be delegated to a central agency of the Federation of State Boards or some other similar organization, for this is a task containing so many pitfalls that it requires the services of trained personnel which are not available to many of the individual state boards of licensure or to hospital administrators.⁷ This would guarantee that at least so far as examinations can determine fitness, those men accepted would possess basic medical knowledge roughly comparable to that of graduates of our own schools. Certainly, anything less than this is unacceptable, and any hospital that delegates responsibility for the care of patients to those who are incapable of passing such examinations must know that it is committing a disservice to American medicine and to the American public.

SUMMARY

The first half of the 20th Century has been a period of unprecedented advance in scientific knowledge, in medical education and in the medical care of patients; yet in the first decade of the century American medical education was in a sorry plight, anyone could start a medical school for profit, there were no standards, no controls, and proprietary schools and diploma mills flourished. A number of factors combined to rectify this deplorable situation, such as the valiant efforts of the recently formed Council on Medical Education and Hospitals of the American Medical Association and the Association of American Medical Colleges. Flexner's brilliant exposition of the inexcusably poor quality of training current in so many schools and, last but not least, the economic factor. That is, the greatly increased cost of educating a student so as to enable him to compete in the practice of the swiftly advancing "new medicine" took the profit out of medical schools, forcing the weaker ones to the wall.

In 1925 Flexner wrote, ". . . an increasingly alert and determined effort, running through the ages, has endeavored to expel superstition, to narrow the range of empiricism and to enlarge, refine, and systematize the scope of observation. . . . The general trend of medicine has been away from magic and empiricism, and in the direction of rationality. . . ."⁸ Gains made in this direction, during the first and second quarters of this century, have indeed been great, but it must be remembered that they were achieved only with hard effort and at high cost. After World War II a variety of new factors intervened. In spite of the sacrifices demanded by high tuition rates and added years of training, young men and women stormed the doors of medical schools in eagerness to undertake the arduous task of becoming physicians. In response, established schools increased their faculties and expanded their facilities, and new schools were opened. More and better prepared students have embarked on the study of medicine each year since the end of World War II, more and better trained physicians have been graduated. Also, financial support by government and by private foundations has by many times multiplied the quantity of research. American medicine reached a leading position in the world.

Accompanying this progress are some difficult new problems. The cost of medical education has

been increasing so rapidly that medical schools have become a heavy burden to many of the private universities of which they are a part. For several reasons, serious difficulties developed in obtaining enough properly qualified basic science teachers to provide for the expansion in size and number of medical schools. Then, just as there began to be some resolution of the problems of finances and faculty personnel, there was an unheralded, marked decrease in the number of applicants for admission to medical schools. So far this is merely a cloud on the horizon, but it may grow into a storm.

Another alarming storm has already burst upon us, and with such suddenness that but few of us even guessed it was approaching. When the recent shortage of interns and residents was causing us such concern, it seemed a happy circumstance that so many graduates of foreign medical schools were anxious to come to the United States; and our hospitals welcomed them with open arms. The number of such foreign trained physicians grew so rapidly, however, that almost before we understood how many of them had no idea of returning to their own lands, and how poorly prepared so many of them were, they were becoming a threat to the high level of our medical practice. For centuries Europe has been regarded as the center of civilization and learning—and the physicians who came to our shores in revulsion from Nazi and Fascist tyranny bore out that high regard. After the war, however, there was a natural but tragic change, though in America only a few people understood that the destructive effects of the war upon the educational institutions in Europe had caused such a decline in medical training that a very high proportion of European medical schools ceased to be able to offer a course of instruction even comparable to that required of every school in this country. These European schools could not possibly obtain accreditation if they were

located in the United States; yet it is from them that a great many graduates come to our hospitals, eventually to practice medicine here. It is ironical that this danger to our medical standards is augmented by our having been at such pains to make the product of American medical schools so uniformly good that the public has lost wariness in the choice of a physician. Thus it becomes additionally our duty today to alert medical men and legislators to the potential seriousness of this situation so that firm steps may be taken to prevent unqualified physicians from being granted licenses to practice medicine.

At this midpoint in the 20th century, medical education, and through it the practice of medicine in the United States, are at the highest level in all history. As practitioners, as educators and as informed citizens, it is our solemn duty not only to maintain this level, but to raise it even higher.

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163rd ANNUAL MEETING
of the
CONNECTICUT STATE MEDICAL SOCIETY

STRATFORD HIGH SCHOOL, STRATFORD

April 26, 27, 28, 1955

PROGRAM COMMITTEE

SAMUEL D. KUSHLAN, *New Haven, Chairman*

JAMES W. MAJOR, *Willimantic*

WALTER WEISSENBORN, *Hartford*

LOCAL COMMITTEE ON ARRANGEMENTS

EDWIN R. CONNORS, *Bridgeport, Chairman*

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STUART L. JOSLIN, *Fairfield*

ARNOLD P. OLSON, *Fairfield*

SIDNEY L. PENNER, *Stratford*

NICHOLAS P. R. SPINELLI, *Stratford*

PROGRAM

Tuesday, April 26

MUSIC ROOM

ANNUAL MEETING OF THE HOUSE OF DELEGATES

COLE B. GIBSON, *Speaker of the House, presiding*

10:00 CALL TO ORDER

BUSINESS SESSION

1:00 LUNCHEON FOR OFFICERS, MEMBERS OF THE HOUSE, AND GUESTS

2:00 RESUMPTION OF BUSINESS

7:00 ANNUAL DINNER OF THE COUNCIL

Wednesday, April 27

9:00 REGISTRATION—Exhibit Hall

AUDITORIUM

9:00 MOTION PICTURE FILM

9:30 CALL TO ORDER—President of the Society

ADDRESS OF WELCOME—Edwin R. Connors, Bridgeport, Chairman, Local Committee on Arrangements

H. M. MARVIN, *New Haven, presiding*

10:00 PRACTICAL PROBLEMS IN THE CARE OF THE AGED

Frederic D. Zeman, *New York*

10:35 NONSPECIFICITY OF THE ELECTROCARDIOGRAM IN CORONARY ARTERY DISEASE

Harold D. Levine, *Boston, Massachusetts*

11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS

SAMUEL D. KUSHLAN, *New Haven, presiding*

11:40 VISUALIZATION OF THE NONFILLING GALLBLADDER OR THE BILIARY TREE AFTER CHOLECYSTECTOMY, WITH A NEW I.V. CONTRAST MEDIUM (CHOLAGRAFIN)

Herbert M. Stauffer, *Philadelphia, Pennsylvania*

12:15 THE DEPRESSED OFFICE PATIENT

Paul H. Hoch, *New York*

1:00 LUNCHEON—Cafeteria of the High School

VISIT TO TECHNICAL EXHIBITS

2:00 Program Arranged by Connecticut Academy of General Practice

President: Julius H. Grower, *Middletown*

Secretary: Peter J. Scafarello, *Hartford*

GOUT—HOW TO RECOGNIZE IT AND TREAT IT

Darrell C. Crain, *Washington, D. C.*

Speaker and Subject to be announced

Discussion period

Wednesday, April 27

MUSIC ROOM

9:15 FILM—Presented by Beckett M. Howorth, Stamford

OLIVER L. STRINGFIELD, *Stamford, presiding*

10:00 CONGENITAL ANOMALIES—CAUSE AND PREVENTION

Theodore H. Ingalls, *Boston, Massachusetts*

10:35 THE OCCURRENCE AND SPREAD OF INFECTIOUS DISEASES IN FAMILIES

William S. Jordan, Jr., *Cleveland, Ohio*

11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS

DAVID H. CLEMENT, *New Haven, presiding*

11:40 HORMONES IN MANAGEMENT OF RHEUMATIC FEVER

Gene H. Stollerman, *Irrington-on-Hudson, New York*

12:15 ALLERGIES IN CHILDREN

Douglas E. Johnstone, *Rochester, New York*

1:00 LUNCHEON—Cafeteria of the High School

VISIT TO TECHNICAL EXHIBITS

MEETINGS OF SECTIONS OF THE SOCIETY AND GUEST ORGANIZATIONS

WOMAN'S AUXILIARY TO THE CONNECTICUT STATE MEDICAL SOCIETY

ELEVENTH ANNUAL MEETING

BROOKLAWN COUNTRY CLUB, BRIDGEPORT

President: Mrs. Newell Giles, *Darien*

Secretary: Mrs. Charles Murray Gratz, *Cos Cob*

(Program to be announced in April JOURNAL)

3:30 Section on Anesthesia

Section on Dermatology and Syphilology

Section on Gastroenterology } Joint Meeting

Section on Radiology

Section on Proctology

Connecticut Society for Psychiatry and Neurology

Connecticut Allergy Society

Connecticut Association of Medical Record Librarians

Connecticut Branch of American Association of Medical Social Workers

Connecticut Regional Group of the Medical Library Association

Connecticut Rheumatism Association

Connecticut Trudeau Society

Hezekiah Beardsley Pediatric Club

7:00 ANNUAL DINNER OF THE SOCIETY—HOTEL STRATFIELD, BRIDGEPORT

Thursday, April 28

9:00 REGISTRATION—Exhibit Hall

AUDITORIUM

9:15 MOTION PICTURE FILM

CLAIR B. CRAMPTON, *Middletown, presiding*

10:00 WHEN SHOULD AN OVARECTOMY BE DONE?

Clyde L. Randall, *Buffalo, New York*

10:35 CHRONIC URINARY BLADDER IRRITATION AND DISABILITY

Clarence G. Bandler, *New York*

11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS

JAMES W. MAJOR, *Willimantic, presiding*

11:40 ROLE OF ANESTHESIA IN SURGICAL MORTALITY

Henry K. Beecher, *Boston, Massachusetts*

12:15 RADICAL PELVIC SURGERY

Langdon Parsons, *Boston, Massachusetts*

1:00 LUNCHEON—Cafeteria of the High School

VISIT TO TECHNICAL EXHIBITS

2:00 Program Arranged by The Connecticut Society of American Board of Surgeons

*President: Louis N. Claiborn, New Haven**Secretary: N. William Wawro, Hartford*

ABUSES OF ANTIBIOTICS

Chester W. Howe, *Boston, Assistant Professor of Surgery, Boston University School of Medicine*

PROBLEMS POSED IN THE CONTROL OF METASTATIC CANCER BY RADIOACTIVE ISOTOPES

Lee E. Farr, *Upton, New York, Medical Director, Brookhaven National Laboratory*

Thursday, April 28

MUSIC ROOM

THOMAS J. DANAHER, *Torrington, presiding*

10:00 THE TREATMENT OF THE PAINFUL SHOULDER

Paul C. Colonna, *Philadelphia, Pennsylvania*

10:35 INDICATIONS FOR SPLENECTOMY

Claude-Starr Wright, *Columbus, Ohio*

11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS

WALTER WEISSENBORN, *Hartford, presiding*

11:40 THE MEDICAL EXAMINER

LeMoyne Snyder, *Lansing, Michigan*

12:15 MANAGEMENT OF CERTAIN COMPLICATIONS IN ACUTE HEAD INJURY

E. S. Gurdjian, *Detroit, Michigan*

1:00 LUNCHEON—Cafeteria of the High School

VISIT TO TECHNICAL EXHIBITS

Thursday, April 28

MEETINGS OF SECTIONS OF THE SOCIETY AND GUEST ORGANIZATIONS

3:30 Section on Aviation Medicine

Eye, Ear, Nose, and Throat Section

Section on Obstetrics and Gynecology

The Connecticut Society of American Board Obstetricians and Gynecologists } Joint Meeting

Section on Orthopedics

Connecticut Society of Pathologists

Association of Medical Examiners in Connecticut } Joint Meeting

Section on Physical Medicine

Connecticut Diabetes Association

Connecticut Chapter, American Physical Therapy Association

Connecticut Occupational Therapy Association

Complete information concerning the meetings of the Sections of the Society has not been received in time for publication in this issue of the JOURNAL. These programs will be printed in the April issue.

HEALTH SERVICES IN CIVIL DEFENSE

3:30 MUSIC ROOM

INTRODUCTION

Benjamin B. Whitcomb, *Hartford; Chairman, Committee on Emergency Medical Service, Connecticut State Medical Society*

HEALTH SERVICES IN CIVIL DEFENSE

Edgar B. Prout, *Hartford; Chief of Health Services, State Office of Civil Defense*

AREA MEDICAL SERVICES

Alfred L. Burgdorf, *Hartford; Health Officer, City of Hartford; Hartford Area Medical Director*

ROLE OF HOSPITALS IN CIVIL DEFENSE

Mr. Stuart W. Knox, *New Haven; Executive Director, Connecticut Hospital Association*

THE BLOOD PROGRAM IN CIVIL DEFENSE

Victor G. H. Wallace, *Hartford; Director, Connecticut Regional Blood Bank, American Red Cross*

RADIATION HAZARDS AND RADIATION MONITORING

Lieutenant Leslie W. Williams, *Director of Training, Connecticut State Police Department, Member of the Radiological Committee in State Civil Defense*

PRE-ATTACK DISPERSAL PLAN

Captain William L. Schatzman, *Connecticut State Police Department, Chief of Security, State Office of Civil Defense*

PANEL DISCUSSION

General William Hesketh, *Hartford; Director, State Office of Civil Defense*

Stanley H. Osborn, *Hartford; Commissioner, State Department of Health*

Mr. Arthur Heubner, *Hartford; Industrial Hygiene Engineer, State Department of Health*

Edward H. Kirschbaum, *Waterbury; Medical Examiner, City of Waterbury, Waterbury Area Medical Director*

THE CONNECTICUT PHYSICIANS' ART ASSOCIATION

1955

EXHIBITION

Receiving—One day only—April 24, 1955—12 noon to 4 P. M. All works must be delivered uncrated by the artist or his agent to the Committee in Charge. Entries are limited to two (2) per person.

Where—Stratford High School, Room 219, King Street, Stratford, Connecticut.

Works Eligible—Original works or copies—if copies, they must be so labeled. Oil, water color, tempera, pastel, black and white, sculpture, ceramics, etchings, photography.

Who May Exhibit? Members of the Medical Society and wives. Members of the Woman's Auxiliary and their children.

Fee—A hanging fee of \$1 will be charged to members for each article. No fee for children. Fee for nonmembers of the Woman's Auxiliary, \$5.

The exhibition will be hung on Sunday, April 24, 1955. No work may be removed until the last day of Connecticut State Medical Meeting, April 28, and must remain as hung by Hanging Committee until that date. Pictures to be exhibited should be suitably framed, ready for hanging.

Further Information—Members who wish to exhibit may contact the following chairmen for further information and entry blanks:

John M. Freiheit, 85 Grove Street, Waterbury
Mrs. Orvan W. Hess, Old Orchard Road, North Haven
Mrs. David M. Waskowitz, 33 Wightman Road, New Britain
Mrs. Bernard S. Brody, Hilltop Road, Hamden
Mrs. Jack J. Blinkoff, 33 Prospect Street, Torrington
Mrs. John R. Maher, 2184 Main Street, Stratford
Mrs. Norman H. Gardner, 22 Summit Street, East Hampton
Mrs. Angelo J. Gulino, Plainfield

or your County President

Works will be judged by professional artists on Sunday evening, April 24.

A special effort will be made this year to recognize merit in each group relative to the experience of the artist so it is IMPORTANT to fill in the entry blank completely, stating the number of years you have been enjoying this hobby.

The Society can assume no responsibility for loss, damage, or any cause whatsoever.

Technical Exhibits — 1955 Annual Meeting

<i>Space</i>	<i>Firm</i>	<i>Location</i>
1	The Coca-Cola Company	Atlanta, Ga.
2	The American Surgical Supply & Equipment Company	Bridgeport, Conn.
3	Ames Company, Inc.	Elkhart, Ind.
4	E. F. Mahady Company	Boston, Mass.
5	Saratoga Springs Authority	Saratoga Springs, N. Y.
6	Pfizer Laboratories	Brooklyn, N. Y.
7	Brewer & Company, Inc.	Worcester, Mass.
8	Ciba Pharmaceutical Products	Summit, N. J.
9	U.S. Vitamin Corporation	New York, N. Y.
10	Smith, Kline & French Laboratories	Philadelphia, Pa.
11	The Purdue Frederick Company	New York, N. Y.
12	M & R Laboratories	Columbus, Ohio
13	A. S. Aloe Company	St. Louis, Mo.
14-15	Sealy Mattress Company	Waterbury, Conn.
16	Connecticut Hospital Equipment & Supply Company	Hartford, Conn.
17	C. B. Fleet Company, Inc.	Lynchburg, Va.
18	Doho Chemical Corporation	New York, N. Y.
19	R. J. Reynolds Tobacco Company	Winston-Salem, N. C.
20	The Borden Company	New York, N. Y.
21	Wm. P. Poythress & Company, Inc.	Richmond, Va.
22	E. R. Squibb & Sons	New York, N. Y.
23	Desitin Chemical Company	Providence, R. I.
24	Parke, Davis & Company	Detroit, Mich.
25	A. H. Robins Company, Inc.	Richmond, Va.
26	American Ferment Company, Inc.	New York, N. Y.
27	Lederle Laboratories Division, American Cyanamid Company	Pearl River, N. Y.
28	Eli Lilly and Company	Indianapolis, Ind.
29	Burroughs Wellcome & Co. (U.S.A.) Inc.	Tuckahoe, N. Y.
30	Pepperidge Farm, Inc.	Norwalk, Conn.
31	The National Drug Company	Philadelphia, Pa.
32	H. J. Heinz Company	Pittsburgh, Pa.
33	Schieffelin & Company	New York, N. Y.
34	The Mitchell Dairy Company	Bridgeport, Conn.
35	Geigy Pharmaceuticals (Division of Geigy Chemical Corp.)	New York, N. Y.
36	Winthrop-Stearns, Inc.	New York, N. Y.
37	VanPelt & Brown, Inc.	Richmond, Va.
38	W. B. Saunders Company	Philadelphia, Pa.
39	E. L. Washburn & Co., Inc.	New Haven, Conn.
40	The G. F. Harvey Company	Saratoga Springs, N. Y.
41	Ives-Cameron Company	Philadelphia, Pa.
42	Maltbie Laboratories Division, Wallace & Tiernan, Inc.	Belleville, N. J.
43	Sandoz Pharmaceuticals	East Hanover, N. J.
44	J. B. Roerig and Company	Chicago, Ill.
45	Abbott Laboratories	North Chicago, Ill.
46	Ayerst Laboratories	New York, N. Y.
47	G. D. Searle & Company	Chicago, Ill.
48	The Stuart Company	Chicago, Ill.
49	The Dietene Company	Minneapolis, Minn.
50	E. Fougera & Company, Inc.	New York, N. Y.
51	Jackson-Mitchell Pharmaceuticals, Inc.	Culver City, Calif.
52-53	Surgeons & Physicians Supply Company	Boston, Mass.
54	The Baker Laboratories, Inc.	Cleveland, Ohio
55	The D. G. Stoughton Company	Hartford, Conn.
56	Schering Corporation	Bloomfield, N. J.
57	Wilfred Pharmaceutical Company	Hamden, Conn.
58	Mead Johnson & Company	Evansville, Ind.
59	Fellows Medical Mfg. Company, Inc.	New York, N. Y.
60	Carroll Dunham Smith Pharmacal Company	New Brunswick, N. J.
61	Warner-Chilcott Laboratories	New York, N. Y.
62-63	The Professional Equipment Company	New Haven, Conn.
Corridor	Connecticut Medical Service	New Haven, Conn.

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

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EDITORIALS

A State Medical School

The idea that a medical school be established in the University of Connecticut was first publicly proposed by Governor Raymond Baldwin at the annual dinner of the State Medical Society May 3, 1944. The Governor's remarks interested the newspapers of course and caused mild comment here and there but apparently not much else at the time. However, the subject was not forgotten and from 1947 to 1955 several official studies of the project were made and a committee from the Hartford County Medical Association also filed a report. Early this year the fifth governmental agency, a commission authorized by the 1953 General Assembly, submitted its findings to the State Legislature. The State Medical Society has never given official consideration to the project.

Each of the successive public groups have approached the problem in about the same way from four aspects:

(a) Is a State medical school necessary to supply physicians needed in Connecticut?

(b) Does the State have an obligation to provide easily accessible and economical medical education for its youth?

(c) Would the creation of a publicly operated medical school and medical center improve health services for the people of this State?

(d) Does Connecticut have a responsibility to educate physicians for the national pool from which it now recruits twice as many as it contributes?

(e) Is it a justifiable expense to the taxpayers?

Up to now the study groups have all answered

(b), (c) and (d) in the affirmative with some qualifications except (b) which seems to have had unanimous acceptance. (a) has not caused much concern and (e) has been largely evaded until the latest report.

The findings of one survey that did not receive much publicity are interesting. It was the report made in 1950 by consultants officially retained to survey higher education in Connecticut. They recommended that the State proceed at once to establish a standard two year preclinical school of medicine at the University of Connecticut at Storrs and move toward the development of a State medical center at Hartford, including a standard four year college of medicine and a standard four year college of dentistry as units of the University of Connecticut in Hartford.

The commission that has just submitted the recommendations that are published in this issue of the JOURNAL has the cumbersome title "The Commission to Study the Establishment of Medical, Dental and Veterinary Colleges on a New England Regional Basis" and is generally known as the "Medical-Dental School Commission" or "Alcorn Commission" from the name of its chairman, Robert H. Alcorn, attorney from New Haven. The appointment of this commission by the General Assembly of 1953 was largely motivated by proposals for a New England Compact for Higher Education, particularly medical education, that had its origin from many sources.

This Commission has reviewed and accepted the data collected and opinions expressed by preceding commissions and has studied in detail the desirability

of creating a New England Regional School of Medicine and Dentistry. Its conclusions are striking and certain. Such a school is recommended to be established in Hartford as part of the University of Connecticut and the capital sum for its creation to be provided by the State of Connecticut. The Commission has implemented its proposals by the introduction of appropriate bills in the General Assembly (HB113, SB40 and SB47). Among other things these bills call for a state bond issue of six million dollars for construction and for the State to join in the New England Compact. Omitted from the bills is any mention of where and under what arrangements the school is to have hospital and clinical facilities.

This is a matter the people of Connecticut are now called upon to decide. There will be many conflicting opinions but it cannot be disputed that it is a development of far reaching importance to the public and to the medical and dental profession.

It may be that during the period of cautious study by Connecticut some of its problems have been answered. Since Connecticut started its deliberations in 1947 nine new medical schools have been organized and are in production or nearly so. They are the State Universities of California at Los Angeles, Florida, Mississippi, Missouri, North Carolina and West Virginia and Miami, Yeshiva (Albert Einstein) and Seton Hall.

Early Detection of Cancer in Physician's Office

The Connecticut program for early detection of cancer of accessible sites, in the physician's office, has had very little impact on either the public or the medical profession since its inception over three years ago. The plan, which has been approved and sponsored by all of the County Medical Associations in the State, had as its principal objection the satisfaction of a relatively small but persistent demand from the public for an examination "to find cancer." A nine point examination, which could be carried out by any physician in his office without the aid of special equipment and in a relatively short time, was proposed, and lists of physicians who agreed to perform at least this minimal type of examination on patients applying for it at their offices was prepared. Unfortunately, through an honest misunderstanding of the nature and purposes of this program, many physicians in the State in the practice of very

limited specialties volunteered to have their names included on the lists, although they did not actually intend to perform this type of examination.

Because the lists were thus demonstrated to be inaccurate, very little publicity was given to this program after the initial announcement, and efforts were begun to revise the lists of participating physicians by correcting these misunderstandings in order to make them of practical value. With the cooperation of the County Associations, these revisions have now been completed and prepared in such a form that corrections due to change of address and to the participation of new members can be readily made.

During this period of time, there has been no decrease in the demand for this type of service, and the inadequacy of the so-called "Cancer Detection Center" to handle this type of examination on a broad enough scale has already been demonstrated. Consequently, with the aid of the American Cancer Society, Connecticut Division, and in accordance with the ethical standards for such purposes previously agreed upon, the availability of this service will once more be publicized by the Medical Society on a modest, continuing basis.

It is recognized that by physical examination alone only about fifty per cent of cancers at a recognizable stage by site of occurrence can be discovered. Nevertheless, experience has shown that many patients presenting themselves for such an examination have symptoms of more deep seated pathology, which come out during the examination and which may lead to subsequent further investigation and the discovery of cancer of inaccessible sites. Even among the group of patients whose symptoms referable to cancer are so minimal that they present themselves as asymptomatic, many incurable cases are found. Nevertheless, it is felt that the distressing number of patients being seen with far advanced symptoms and pathology may be materially reduced by this type of examination.

Solving the Tuberculosis Problem

The Metropolitan Life Insurance Company has recently issued an interesting volume on their forty year campaign against tuberculosis written by Dr. Louis I. Dublin, their chief statistician.* It will be recalled that the Company established a sanatorium

*A 40 year Campaign Against Tuberculosis. Louis I. Dublin, PH.D., Metropolitan Life Insurance Company, 1952.

for the care of their tuberculous employees at Mount McGregor, New York, about nine miles north of Saratoga Springs in the foothills of the Adirondacks. It was located on an estate of 600 acres where Ulysses S. Grant had passed his declining years. General Grant had often commented on the healthfulness of the site and had frequently suggested that it would be an ideal spot for such an institution.

In the planning, construction, and conduct of the sanatorium the counsel of physicians especially trained in the problems of tuberculosis was employed, advice was freely given by nationally-known experts and contact with the National Tuberculosis Association was maintained. The Company was largely responsible for effecting the well-known Framingham Community study of the disease, they conducted clinical, pathological and statistical studies of the disease, put on an active campaign of education regarding it and contributed funds to various agencies concerned with the study of the disease. In brief, the Metropolitan was for 40 years an active participator and activator in the study of tuberculosis, a contribution to the public welfare of major importance.

While the various steps which were taken in this lengthy study are clearly and graphically described, the most interesting chapter in the book is, in the writer's opinion, the last. This discusses "The Present Status and Outlook for the Tuberculosis Problem." Opinions on this must, as Dr. Dublin points out, be based on an analysis of a number of factors: (1) the mortality from the disease, (2) the current trend of morbidity and the effect on this of race, geographical distribution, and occupation, (3) the influence of age, (4) the effect of social and environmental conditions such as living standards, housing, quality and quantity of medical care, and suitable hospital and sanitary facilities. Nor must we forget the human element for such factors as inertia, ignorance and pure cussedness may lead patients to neglect medical consultation and to fail to carry out the suggestions of their physicians.

The Census of 1950 showed an over-all mortality from tuberculosis in the United States of 22 per 100,000 of the population and this has probably dropped since then. This is a decline of 90 per cent in the past 40 years and of more than 50 per cent in the past ten years alone.

The facts regarding morbidity are complex and difficult to evaluate. It is clear that the mortality is above the average in American Negroes, American

Indians, Mexicans and Chinese residing in this country and in Puerto Ricans. Where intensive case-finding surveys have been conducted in recent years there has been, in some localities, an actual rise in morbidity. In many places tuberculin testing has shown an undoubted decline, especially among children and young adults. Recent mass x-ray studies have discovered many unsuspected consumptives, especially among the older males. But newer treatments both medical and surgical have kept many patients alive who would formerly have succumbed.

Exactly how many patients with tuberculosis there are in the United States no one knows. The National Tuberculosis Association estimates that there are still 400,000 with active disease. Interesting maps in the report on morbidity and mortality show that both vary considerably in different States of the Union. There is a mortality of 40 per 100,000 or over in Arizona, New Mexico and Kentucky, while a morbidity of 150 per 100,000 exists in Arizona, New Mexico, Colorado and Tennessee. Formerly, when more stress was laid on the importance of climate in treatment, many tuberculous patients with their families migrated to Arizona, New Mexico and Colorado.

The effect of occupation on the incidence of tuberculosis has been known for generations as such old terms as knife-grinder and coal-miners phthisis indicate. Any occupation associated with silicosis predisposes to the disease. The experience of the war years, during which some normally well fed populations were on insufficient diet, clearly showed an increase in morbidity and mortality. No doubt too, overcrowding and inadequate housing play a part. Chronic alcoholism, perhaps indirectly through leading to dietary deficiencies, may be a factor.

There is no lack of evidence that the problem is not yet solved and that the fight must be continued. Recent x-ray surveys have led to the treatment of many patients formerly neglected but sanatorium treatment is often prolonged and many patients fail to give it a fair trial. The suggestion of J. A. Myers that every patient with a positive tuberculin reaction should be treated intensively by the newer drugs deserves trial.

G. B.

Our Medical World

In the interest of improving the contents of the JOURNAL we offer our readers in this issue the initial

installment of material comprising a new department in the JOURNAL entitled "Our Medical World." This material is made possible by the interest of one of the members of the editorial board in the affairs of physicians outside the boundaries of the United States.

The increasing numbers of foreign born physicians who are securing experience in our hospitals and appearing before our State licensing boards have already created a practical interest in the problems of medicine in other countries. Those of this number located in Connecticut should find this addition to the JOURNAL worthwhile. We anticipate that our other readers may be able to broaden their present knowledge through perusal of this new department from month to month. We can no longer afford to be provincial in a day when distances mean nothing but mutual understanding is essential to a beneficent existence on this planet.

A Good Book

Jim Bryan's many friends who have watched his progress in the field of administrative medicine are not surprised that he has written a book about it. Although not trained in medicine, he absorbed a great deal during his youth with a respected father who was perhaps a doctor of the fanciful "old school," but as far as Jim was concerned, he was of the "best" school. From that background and a rich experience as executive officer of medical organizations, a good book, "Public Relations In Medical Practice" has been produced and its author is to be congratulated.

There are many complimentary things said about the expanding public relations program of organized medicine and the various projects whose common denominator is a demonstration of the profession's interest in the public welfare. But, the author finds the essence of it all in "the traditional ethics of the profession, its ancient ideal of service and its noble code of conduct." For the individual doctor "good public relations . . . is identical with the consecrated spirit and good conduct of the physician. It is a way of life—nothing more, nothing less."

The bulk of the book is bright and never tedious pages aimed at better understanding of the complex problems involved in the public relationships of the doctor. Much good advice is offered about all kinds

of things that are a part of the physician's busy days in youth and maturity alike.

But finally the thoughtful author returns to his primary ideal and it is good that he does so for therein lies the truth. He observes in conclusion, "that public relations for the doctor may be summed up as a matter of attitude toward his patient, his profession, his community, his job—and himself. His knowledge of physic, his acumen and skill in administering the marvelous scientific armamentarium that his forebears have bequeathed him will profit him and his patient little indeed if his spirit is not made humble and his hand made gentle by human compassion."

Perhaps without realizing it Mr. Bryan has written a practical thesis on what Sir Richard Livingstone has so gracefully called "the Philosophy of the First-Rate."

Journal of Chronic Diseases Makes Its Bow

In January of this year arrived the first issue of the *Journal of Chronic Diseases* to appear monthly hereafter. As the editors say: "It is a new venture in medical literature, which finds its stimulus and reason for being in an awakening medical and public interest in the increasing importance of chronic illness." Of this there can be no doubt if one will only consult the voluminous report of the Magnuson Commission on the Health Needs of the Nation appointed by the President in 1951.

The recognition of the need for institutions where the chronically ill may be properly housed and cared for is becoming more apparent each year. Congress is implementing the fulfillment of this need with increased appropriations.

This new journal is interested in the problems of the chronically ill at their inception. It plans to publish articles on chronic illness as it affects any part of the medical and ancillary professions and thus save the interested reader the necessity of perusing a large number of medical journals. The authors even suggest that the new journal may carry a Section on Negative Results to save unnecessary duplication of effort in any given field.

The editorial board is an imposing one covering clinical medicine and scientific research. The JOURNAL extends its congratulations to the new baby and best wishes for a prosperous and stimulating career.

THE PRESIDENT'S PAGE

WILL WE ACCEPT THIS CHALLENGE?

IN the year 1954, 12.6 per cent of the members of this Society contributed to the support of the American Medical Education Foundation, widely known as AMEF. This placed Connecticut in fourteenth place, but in number of contributors it was eleventh. On the basis of the number and percentage of physicians and the total amount contributed Connecticut was on the AMEF's Honor Roll of States for the second year.

While we may find gratification in these facts, we must simultaneously feel disappointment at the knowledge that Connecticut owes its position to the actions of a very small percentage of its physicians. It is my own conviction that the percentage will rise rapidly as our members become aware of the desperate need of the medical schools for financial support. Let me cite very briefly some of the many facts compiled by the AMEF that should be known to every physician.

The 80 medical schools now train approximately 27,000 undergraduates and 55,000 other scientists doing graduate work. They graduate more than 6,000 doctors annually, a number that must increase if it is to meet the needs of a growing population. A lowering of teaching standards or reduction of medical manpower would be disastrous. . . . Medical training is far more expensive than any other form of education. The average cost of training a physician is about \$10,000, and tuition fees pay only one-fifth of this. On the average, medical schools take 30 per cent of total university budgets, yet have only 10 per cent of the enrollment. Many universities are wondering if they can possibly continue their medical schools, since total income is no longer adequate to meet current needs. Three private schools have recently merged with tax-supported State universities. . . . The medical schools need more than ten million dollars annually to maintain current standards. If such support is not received, medical training will deteriorate rapidly and the number of graduates will decline. Funds can come only from private or governmental sources. Governmental subsidy implies government control, at first of the medical schools and later of all aspects of medical practice.

There is a closely affiliated organization known as the National Fund for Medical Education, which solicits contributions from business corporations. Its directors have expressed the belief that if physicians will voluntarily contribute two million dollars annually, the National Fund will be able to raise eight million. For the past three years the American Medical Association has contributed one-half million dollars annually to AMEF, but has now reduced this to \$100,000 a year, believing that individual physicians and their medical societies should and will assume this additional responsibility.

One important function of AMEF is to provide a central office through which ALL contributions from physicians to medical schools can pass, thus affording ready proof to interested members of Congress and to directors of corporations that doctors are aware of the great need and are eager to help meet it. It is known that hundreds of physicians contribute directly to medical schools (undoubtedly many in Connecticut did this), but if these contributions were made through AMEF the schools would receive exactly the same amount, and AMEF would be helped enormously in its vital public-relations function. Contributions to AMEF may be earmarked for any approved medical school in the United States, and every dollar will be transferred to the designated institution, since all administrative costs are paid by the AMA. Thus each contribution serves two purposes: it helps the schools carry their financial burden, and also becomes immediately a matter of record to attest to the interest and loyalty of physicians.

There are few of us who have contributed so bountifully to our schools as to repay even the cost of the education we received. Is it not altogether fitting that we now show our gratitude in a manner that will help them to survive this critical period? I do not forget that doctors, like other citizens, are unable to contribute to all the worthy causes for which they are solicited each year. But it seems to me that AMEF should stand very high on every doctor's list of approved organizations. It is not only our duty to help support the medical schools, but it is also a great privilege to have a part in preserving their freedom and maintaining their high standards of teaching and research. Connecticut physicians have a long and distinguished record of achievement. Let us make it even finer by enrolling at least 75 per cent of our members as contributors to AMEF this year.

H. M. Marvin, M.D.

The image features a background of concentric circles in shades of grey and black, creating a tunnel-like effect. The text 'ACH' is prominently displayed in a bold, orange, sans-serif font with a black outline, positioned on the right side of the image.

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Acute Pyelonephritis
Chronic Pyelonephritis
Mixed Bacterial Infections
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PROGRESS IN CLINICAL MEDICINE

CARDIOSCOPIC MONITORING IN CLINICAL ANESTHESIA

AARON BOBROW, M.D., *Hartford*

THE electrocardiograph is a commonly used tool in the armamentarium of the practising physician of today. Historically, records of electromotive force from the precordium were made as long ago as 1887 by Ludwig V. Waller. Through the years since Einthoven devised the string galvanometer in 1903, studies of the electrical phenomena of the heart have been intensified. Now, specific patterns have been delineated for normalcy and pathology. With the oscilloscope, means are available to constantly survey the electrocardiographic status of the heart at any given moment.

The electrocardiogram is useful in many ways. It can determine the cardiac mechanism as well as indicate the presence of myocardial change. Particularly does it show myocardial ischemia and injury, as in angina pectoris or death of myocardium resulting from coronary occlusion. The electrocardiogram shows the effects of various drugs such as digitalis and potassium. It also indicates various conduction defects and may be of great value in establishing an etiologic, anatomic, and prognostic cardiac diagnosis, especially when considered with other clinical data. Particularly these latter principles offer the anesthesiologist welcome aid, when dealing not only with the poor risk patient, but also with the average risk one. The average daily operative schedule of any general hospital presents frequent cardiac as well as anesthetic problems.

It is a well recognized fact that disturbances in cardiac rhythm are frequently seen during anesthesia with various agents.^{1,2} Research has shown that the efficiency of the heart may be impaired by arrhythmias associated with tachycardias, nodal rhythm, the wandering pacemaker, ectopic foci and the extra systoles. These arrhythmias will very often escape the palpating finger. They are more easily detected by the stethoscope on the precordium. Obviously, however, the electrocardiograph is infinitely more reliable.

In 1936, Kurtz and his co-workers recorded electrocardiograms demonstrating the occurrence of

The Author. *Resident in Anesthesiology, Hartford Hospital*

SUMMARY

The effects of anesthetic agents on the conduction mechanism of the heart were studied by means of an oscilloscope coupled with a direct writing electrocardiograph. Thirty random surgical cases were studied, before, during, and immediately after surgery. By means of the oscilloscope the mechanism of the heart action was kept under constant observation. Various arrhythmias were noted. Some observations are made in an attempt to correlate technique of anesthesia and depth of anesthetic plane to the arrhythmias noted.

arrhythmias with cyclopropane.³ They reported an incidence of 56 per cent of their patients exhibiting them. In 1936 Waters reported on a large series of cases, wherein he found only up to 12 per cent showing arrhythmias. He, however, determined his arrhythmias solely by the palpating finger on the pulse. His studies were confirmed by Meek in 1937.⁴ The percentage difference is obviously significant. Harken, in 1950, pointed out most vigorously that therapy of the dysrhythmias, to be rational, presumes first a proper diagnosis.⁵ Burstein and his co-workers, in 1950, did a series of electrocardiographic studies during endotracheal intubation under anesthesia.^{6,7,8} These studies showed electrocardiographic disturbances in 68 per cent of the patients intubated under anesthesia.

It was felt that the further study of these electrocardiographic disturbances during anesthesia by means of oscilloscopic monitoring was warranted. At the Hartford Hospital, a large general hospital with an active surgical schedule, use was made of an oscilloscope coupled with a direct writing electrocardiograph. The subjects were taken at random from the daily schedule. For the purposes of the study no attempt was made to pick the patients of

any particular age, sex, or physical category. Tracings were taken preanesthetically of leads 1, 2, 3, AVR, AVL, and AVF. The patients were then induced and anesthesia was continued. Tracings were taken during induction, during intubation and at onset of operation. The oscilloscope was monitored and whenever abnormalities were noted, lead 2 tracings were taken. Where indicated, therapeutic measures were taken and the effect noted and recorded by further tracings. Electrocardiograms were also recorded during extubation and prior to removing the patient from the operating table.

During the study various anesthetics were used. A total of 30 patients were observed. All but one patient were induced with a solution of pentothal in a concentration of 2.5 per cent. Twenty were anesthetized with cyclopropane and ether, six with pentothal and nitrous oxide, two with nitrous oxide and ether and two with pentothal, nitrous oxide and trilene. Intubation was performed in twenty-five instances after administration of Anectine to produce muscular relaxation. Thirteen or forty-three per cent in the series exhibited arrhythmias.

Various forms of arrhythmias were encountered. Many of these were of very short duration and had no clinical significance. However, the list of abnormalities noted was significant. Thus sinus tachycardia, nodal rhythm, right and left ventricular extra systoles, a wandering pace maker, bigemini, premature auricular contractions, ventricular tachycardia and heart block were noted (Figure 1, a-e). Without the cardioscopic evidence the anesthesiologist might well have doubted the existence of any unusual state of affairs.

There appeared to be a definite correlation between the arrhythmias and intubation, onset of operation, vigorous exploration, hypoxic states, deep planes of anesthesia and cardiac manipulation or dislocation. Each patient apparently had a specific threshold of sensitivity to anesthesia, in that arrhythmias could be produced almost at will by varying the anesthetic plane beyond certain depths (Figure 2, a-e). Vigorous ventilation with oxygen, in the presence of arrhythmias, had a remedial effect (Figure 3). This was especially evident when the arrhythmia appeared after intubation. Similarly, it was noted that no arrhythmias were encountered in the five patients to whom pentothal and nitrous oxide were administered. At no time did curare cause any observable arrhythmia.

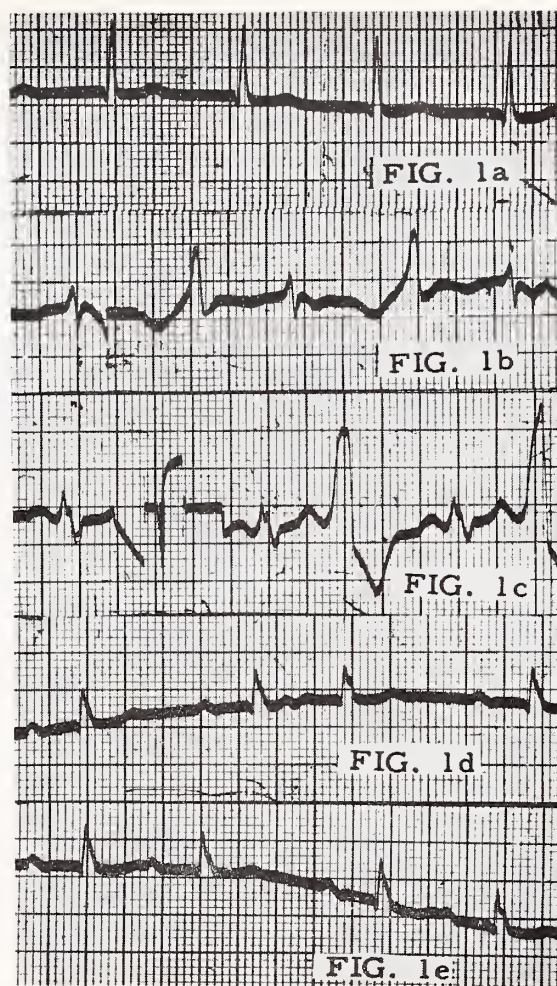


FIGURE 1

Cardiac arrhythmias during general anesthesia

- a. Nodal rhythm.
- b. Left ventricular extra systoles.
- c. Right ventricular extra systoles.
- d. Premature auricular contractions.
- e. Bigeminal rhythm.

The relationship of cardiac arrest to a particular sensitivity of a patient to depth of anesthesia with a specific anesthetic agent might well be explored further. A case in point is that of patient L. S., a 44 year female, apparently in good health, except for a presenting complaint of menometrorrhagia. No history of cardiac disease was elicited. Preanesthetic electrocardiographic tracings were normal (Figure 4, a, b and c). This patient was scheduled for a total hysterectomy. She was induced with 6 cc. of pentothal in a concentration of 2.5 per cent (Figure 4, d), followed by administration of cyclopropane and ether (Figure 4, e). Anectine 40 mg. were given and intubation was performed without difficulty. Immediately after intubation, oscilloscopic monitoring

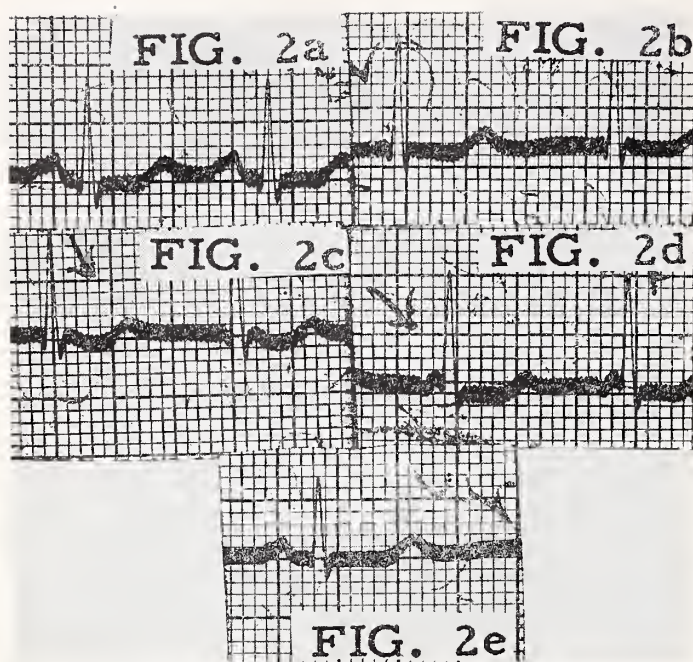


FIGURE 2

Arrhythmias produced by deepening cyclopropane anesthesia.

- a. Normal sinus rhythm lead 2.
- b. Nodal rhythm.
- c. Nodal rhythm with negativity of the ST segment with cyclopropane stage 3, plane 3.
- d. Emergence of "p" waves, upper plane 2.
- e. Normal sinus rhythm plane 2.

demonstrated a bizarre pattern of extra systoles (Figure 4, f). The patient was ventilated vigorously with oxygen, with return to normal of the electrocardiogram. The anesthetic plane was deepened with cyclopropane. A marked bradycardia, rate 42, with disappearance of the "p" waves and negativity of the ST segment appeared (Figure 4, g). Persistence with this plane of anesthesia was deemed dangerous. Lightening of the anesthetic plane resulted in recovery of a normal electrocardiographic pattern, but did not permit proper surgical exposure (Figure 4, h). Ether was substituted, but a level below lower plane one caused recurrence of the electrocardiographic changes (Figure 4, i, j). Inasmuch as the electrocardiographic pattern could be maintained at normal, with the patient in plane one, she was maintained in this fashion through a two hour procedure with nitrous oxide, ether and controlled respiration. During this phase, careful monitoring of the oscilloscope showed no abnormal pattern of cardiac action (Figure 4, k and l). It seemed fairly obvious that had this patient been carried in a deeper plane of anesthesia, with resultant inefficiency of the

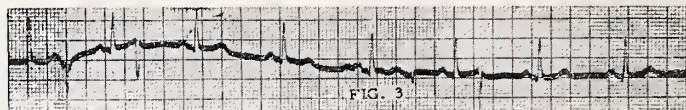


FIGURE 3

Vigorous ventilation with oxygen, emergence of normal rhythm.

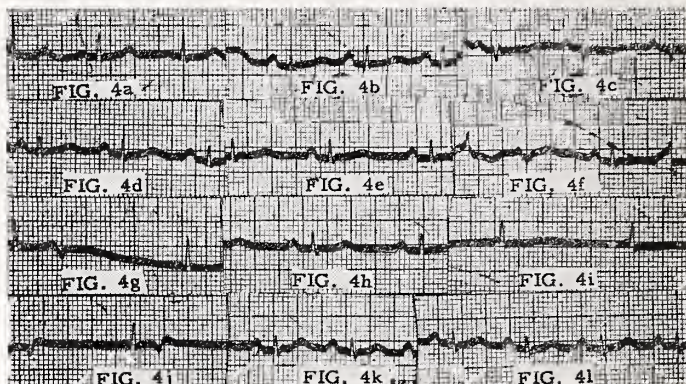


FIGURE 4

Case study—L. S.

- a. - c. Pre anesthetic E.K.G., leads 1, 2 and 3.
- d. E.K.G. after 6 cc. 2.5 per cent pentothal.
- e. After 5 minutes of cyclopropane and ether.
- f. After intubation.
- g. Cyclopropane plane 2.
- h. After lightening the anesthetic plane to lower plane 1.
- i. and j. With ether anesthesia, lower plane 2.
- k. and l. Lower plane 1, controlled respiration.

cardiac output due to myocardial ischemia indicated by the electrocardiographic tracing, the stage might well have been set for a cardiac arrest.

This illustrates a situation which might apply to many of the patients in the series. Levels of tolerance to deeper levels of anesthesia vary from patient to patient as indicated by the random appearance of conduction defects in many instances (Figure 5). Many investigators have dismissed these irregularities as functional aberrations.^{9,10} However no amount of reassurance can remove the uneasy feeling one has when his palpating finger detects a bigeminal rhythm or a severe tachycardia. This study showed that where the arrhythmias were allowed to persist, the pacemaker moved progressively down the conduction system. Under these circumstances one might logically expect a dysrhythmia to develop which would impair the efficiency of the cardiac output. The literature concerning the cardiac arrest is replete with admonitions regarding hypoxia, inadequate ventilation, carbon dioxide accumulation and deep levels of anesthesia. To these should be added

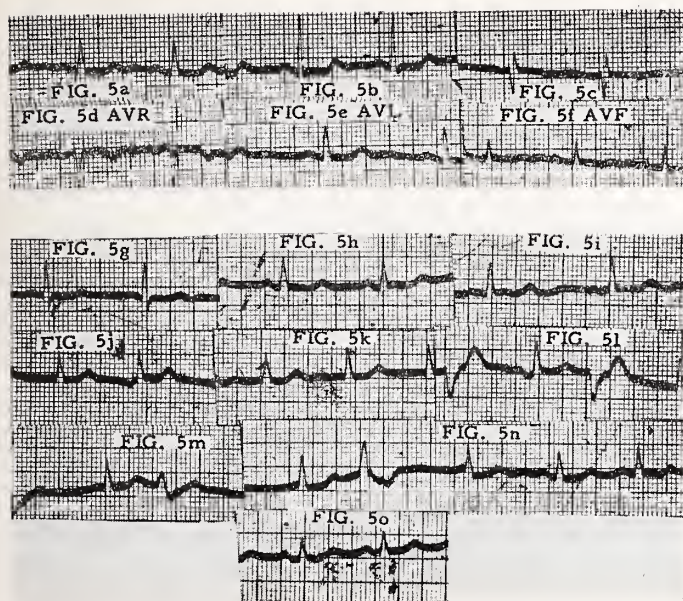


FIGURE 5

Pre anesthetic tracing.

a. - f. Leads 1, 2, 3, AVR, AVL and AVF.

g. After pentothal 2.5 per cent 8 cc.

h. After Anectine 40 mgm.

i. After intubation, nodal rhythm.

j. Emergence of "p" wave.

k. and l. Right and left ventricular extra systoles with deep cyclopropane.

m. and n. Emergence of normal pattern with lightened anesthesia and vigorous ventilation with oxygen.

o. Normal lead 2 after extubation.

the individual idiosyncrasy to depth of anesthesia. The latter can be determined only by oscilloscopic study. Further investigation using the oscilloscope and direct writing electrocardiograph may well add to our knowledge of the origin and development of cardiac arrest. It is planned to follow this preliminary report with a continuing study to be reported at a later date.

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THE CONNECTICUT SOCIETY OF AMERICAN BOARD OBSTETRICIANS AND GYNECOLOGISTS, INC.

Essay Contest—Obstetrics and Gynecology, Prize \$100

I. (a) Applications for entry in the contest should be submitted in writing and mailed to the Secretary, Joseph Klein, M.D., 80 Farmington Avenue, Hartford, Connecticut, not later than April 1, 1955. The applicant should furnish his name, address, hospital address and resident or intern status.

(b) To qualify the applicant must be a graduate in medicine (M.D.) who is serving as an intern or resident (including the various degrees of residency) in any of the recognized hospitals in Connecticut.

(c) The secretary shall assign a code number to each applicant. Each essay must be signed by number (not by name) and submitted to the secretary not later than September 15, 1955. The secretary will then forward it to the judges. The award will be made by number, after which the secretary will refer to the code, determine the name, and inform the judges.

II. (a) The essay must be on an obstetrical or gynecological subject. The format should be similar to that of the usual medical articles as published in medical journals. It should contain: (1) a brief historical summary leading up to the problem; (2) a reasonably detailed report as to investigative work; and (3) general discussion and summary. Original work or a research problem will be given preference over reviews.

(b) The essay must contain not less than 2,500 nor more than 5,000 words.

(c) An original and two copies of the manuscript must be submitted. It must be typewritten, double-spaced and with adequate margin for notations. All copies are to be retained by the Society. One copy will be returned if so requested. The manuscript is to be signed by assigned number—not by name.

III. The amount of the prize is \$100.

IV. The winning essay is to be submitted for publication in the *CONNECTICUT STATE MEDICAL JOURNAL*.

V. Announcement of the winner and awarding of the prize will be at the annual dinner of the Society, at which the winner will be a guest of honor.

THE SECRETARY'S OFFICE

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160 ST. RONAN STREET, NEW HAVEN
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CALL

ANNUAL MEETING OF THE HOUSE OF DELEGATES

The 1955 Annual Meeting of the House of Delegates will be held in the Music Room of the Stratford High School, Stratford (use King Street entrance) commencing at 10:00 o'clock in the morning of Tuesday, April 26.

Following luncheon, the House will reconvene for the completion of business.

H. M. Marvin, President
Creighton Barker, Secretary

INTRODUCTION OF RESOLUTIONS

Article VII, Section 4 of the By-Laws of the Society provides:

Par. 1. All resolutions to be introduced before the House of Delegates at an annual, semi-annual or special meeting, except resolutions and recommendations from the Council and resolutions and recommendations that may be contained in committee reports, shall be delivered to the Executive Secretary in time for publication in the official agenda for the meeting at which action is to be taken.

Par. 2. Resolutions and recommendations to be introduced before the House of Delegates at an annual, semi-annual or special meeting by the Council or resolutions and recommendations that may be contained in reports of standing or special committees of the Society shall be published in the official agenda for the meeting at which action is to be taken. The official agenda shall be distributed to the members of the House of Delegates at the earliest possible date preceding the meeting.

Par. 3. Resolutions and recommendations which do not meet the requirements of Paragraphs 1 and 2, of Section 4 of this article may be accepted for action by a session of the House of Delegates by a majority vote of the delegates present. Such resolutions and recommendations shall be referred at once by the presiding officer to reference committees appointed by him from the membership of the House. These reference committees shall consider the resolutions and recommendations referred to them and shall report, with recommendations, to the House before adjournment of the session.

Delegates to Annual Meeting

The By-Laws of the Society provide that each county association is entitled to one delegate in the House of Delegates for each thirty-five members in the association or fraction thereof based on the membership as of December 31 of each year. According to this, the quota of delegates from each county association who should attend the April Meeting of the House of Delegates which will be held in Stratford, April 26 and the Semi-Annual Meeting in December is as follows:

COUNTY	MEMBERSHIP	OFFICIAL
	DECEMBER 31, 1954	DELEGATES
Fairfield	779	23
Hartford	903	26
Litchfield	124	4
Middlesex	103	3
New Haven	849	25
New London	170	5
Tolland	16	1
Windham	64	2

The secretary's office will appreciate being informed as soon as possible the names and addresses of all the delegates who will represent your county at the Annual Meeting of the House of Delegates in Stratford. The agenda for the meeting is now

being prepared and will be delivered to each delegate as soon as possible. If any delegates cannot attend the meeting the State Secretary's office should be notified.

Election of Councilors and Alternate Councilors

Councilors and Alternate Councilors should be elected for a term of two years at the annual meeting of the county associations this year in Hartford, Middlesex, New London and Windham counties. No Councilor or Alternate Councilor elected by a county association shall serve more than three successive terms of two years each in his respective office, but after a lapse of one term of two years, such Councilor or Alternate Councilor may be eligible for re-election.

Appointment to Committee on Professional Relations

The By-Laws require that the county associations in Hartford, Middlesex, New London and Windham counties at their annual meeting in 1955, elect a past-president of the association to serve for two years on the state Committee on Professional Relations. No member of the Council of the State Medical Society is eligible for election to this committee and no member shall be elected to serve two consecutive terms.

Council Meeting

The monthly meeting of the Council was held at the offices of the Society on January 19, 1955. The meeting was called to order by the chairman at 3:30 P. M. There were present in addition to the Chairman Dr. Danaher, Drs. Marvin, Stringfield, Couch, Barker, Weld, Murdock, Gildersleeve, Gibson, Feeney, Fincke, Gallivan, Ursone, Tracy, Russell, Labensky, Gens, Clarke, Walker, Buckley, Dwyer, Archambault, Gilman. Absent: Drs. Flaherty and Ottenheimer.

A report on the response to a questionnaire concerning the Conference of County Officers was presented (AMB 1/19/55 "A"). It disclosed a lack of interest in the project on the part of the county officers and it was voted to omit the Conference in 1955.

A report was presented concerning the Course on Economics of Medical Practice (AMB 11/10/54 "D") being given at the Yale School of Medicine under the auspices of the Society and the executive secretary stated that two sessions that had been held were well attended and interest was evident. Programs of the course were distributed.

The gift of the portrait of the late Dr. Charles W. Perkins of Norwalk in his will was announced and the portrait exhibited. The secretary was directed to acknowledge this gift which has already been done in correspondence with Dr. Perkins' daughter and it was agreed that the portrait should be hung in the JOURNAL office.

A gift of \$200 from the unexpended funds of the Allied Medical Arts Committee was announced and Dr. Feeney, chairman of the Committee was asked to discuss it. He stated that it was given to the Society for any educational purpose in which the Society might engage, and it was agreed that it be included in the appropriation for medical school scholarships in 1955.

It was voted to continue membership in the Conference of Presidents and Other Officers of State Medical Associations and that the assessment for 1955 in the amount of \$75 be paid.

Dr. Gallivan, chairman of the Subcommittee on Insurance (AMB 10/13/54 "C") presented an interesting and detailed report on the committee's deliberations and recommendations in regard to a retirement plan for employees of the Society. Dr. Gallivan did not have a written report because the Subcommittee on Insurance had met immediately prior to the Council meeting and no time had been available to prepare such a report. However, he stated that he would prepare a report that could be included in the permanent files.

A proposal made by the Committee was that a pension trust type of plan including life insurance be established to which the employees would make contributions and the Society would also contribute. The executive secretary is not to be included under this plan, but other arrangements for retirement will be made for him and paid for without insurance funding.

The cost to the Society for the present number of employees at present salary rates is estimated to be about \$3,500 a year for the first ten years, after which it will decline because the back funding for

years of service already put in will have been paid. The amount of the Society's contribution will increase if the number of employees increases and as salary rates increase.

It was voted to recommend to the House of Delegates at its Annual Meeting in April that the Society adopt this plan retroactive to January 1, 1955, and that funds be appropriated from the unallotted surplus of the Society to meet the cost in 1955 and that thereafter the estimated annual cost become a fixed item in the annual budget.

The changes that had been proposed in the By-laws of Connecticut Medical Service by the Board of Directors of Connecticut Medical Service (AMB 1/19/55 "B"), that would enlarge the Professional Policy Committee of CMS and establish new methods of appointment to the committee, were explained by Dr. Danaher and discussed at great length. There was general approval of the proposals as presented, but suggestions were made to improve and clarify the phrasing of them. It was voted to express approval after these changes were made.

The following recommendation from the Subcommittee on School Health was approved.

"It was recommended that the State Medical Society take the initiative by setting up a Program Committee in cooperation with the Departments of Health and of Education, the Yale School of Public Health and the State Dental Society. This could be an all day meeting or an afternoon and evening meeting. It might have an initial didactic or panel period, then would break up into properly led discussion groups, then reconvene for discussion. It could be led to the formation of an Association of School Medical Advisors, possibly as a section of the State Medical Society, and to the formation of a guide book for School Medical Advisors."

A request from the Connecticut Chapter of American Academy of Pediatrics that the Society establish a Committee on Accident Prevention was approved and the chairman was directed to appoint such a committee. The committee consists of John F. Kilgus, Litchfield, chairman; Norman H. Gardner, East Hampton and Stuart L. Joslin, Fairfield.

No action was taken on the Recommendation from the Committee on Industrial Health (AMB 1/19/55 "C") that the "Guiding Principles of Occupational Medicine" adopted by the Council on Industrial Health of the American Medical Association be accepted by the Connecticut State Medi-

cal Society. The subject was discussed by many and the reasons for not approving the recommendation from the Committee on Industrial Health were that:

1. The Society some time ago approved a "Code of Ethics" relating to Occupational Medicine in Connecticut which goes further and is more comprehensive than the "Guiding Principles of Occupational Medicine" promulgated by the Council on Industrial Health of the American Medical Association and

2. If the "Guiding Principles" have been approved by the Council on Industrial Health of the American Medical Association, it is not understood why they have to be approved by this Society.

Consideration was given to the Report of the Connecticut Legislative Commission appointed to study the Establishment of Medical, Dental and Veterinary Colleges on a New England Regional Basis (Alcorn Commission). (AMB 1/19/55 "F"). Although entire copies of the report are not yet available for general distribution, some of the contents of the report have been made public through the newspapers. It was voted that the chairman of the Council appoint a special Committee to review the report when it becomes available and to analyze the recommendations, and to report its findings to the Council and to the Society's Committee on State Legislation at the earliest possible time. The committee consists of Louis P. Hastings, Hartford, chairman; David J. Cohen, Meriden; Frank H. D'Andrea, Stamford; Chester W. Fairlie, Jr., Hartford; Herbert Thoms, Hamden. The Committee will present its report to the Council on February 17.

A request from the Conference Committee with the State Dental Association that the Society cooperate with that Association in arranging and financing a statewide Conference on Cleft Palate Rehabilitation, was approved and an appropriation not to exceed \$100 was authorized to help defray the expenses of the conference.

Dr. Henry Louderbough, Watertown, was appointed a member of the Committee on School Health.

An amendment to the Medical Practice Act that has been introduced to the Connecticut General Assembly by the Connecticut Medical Examining Board (AMB 1/19/55 "D") was presented as a matter of information and discussion. Another bill that originated with the Legislative Council which would require permits for persons to possess hypo-

dermic syringes and other similar devices was discussed. It would require that such permits be issued under regulations to be established by the Connecticut Medical Examining Board and issued on forms provided by the Board.

It was the unanimous opinion of the Council that such a procedure would put the Medical Examining Board into a police function which it is not equipped to carry out and that if the measure is to be approved by the Society, it should be amended to place the responsibility for the regulation of permits in the State Department of Health. The Society's Committee on State Legislation is to be informed of this opinion by the Council.

It was voted that the President of the Society write to Governor Ribicoff urging the reappointment of Stanley H. Osborn as State Commissioner of Health.

Eleven student members were elected.

Phyllis T. Bodel, Lakeville
Harvard Medical School—Class of 1958
Pre-Med: Radcliffe College
Parent: John K. Bodel

Edward J. Casey, Thompsonville
Georgetown University—Class of 1958
Pre-Med: St. Michael's College
Parent: John E. Casey

L. Ronald Homza, Bridgeport
Creighton Medical School—Class of 1958
Pre-Med: Fairfield University
Parent: Joseph Homza

David J. LeTourneau, Meriden
Tufts Medical College—Class of 1958
Pre-Med: Wesleyan University
Parent: Phillippe B. LeTourneau

Elliott M. Marcus, Danbury
Tufts Medical College—Class of 1958
Pre-Med: Yale
Parent: Kalman Marcus

Matthew S. Monte, Stratford
University of Pittsburg School of Medicine—
Class of 1958
Pre-Med: University of Bridgeport
Parent: Salvatore Monte

Patrick S. O'Halloran, Stamford
Creighton Medical School—Class of 1958
Pre-Med: St. Mary's College
Parent: George E. O'Halloran

Alan Pavel, Stamford
University of Chicago School of Medicine—
Class of 1958
Pre-Med: Yale
Parent: Harry N. Pavel

Clarke Russ, Old Greenwich
Albany Medical College—Class of 1958
Pre-Med: Colgate University
Parent: John M. Russ, Jr.

Roy B. Sherman, Madison
Yale School of Medicine—Class of 1958
Pre-Med: Brown University
Parent: LeRoy B. Sherman

Richard Singer, Danbury
University of Chicago School of Medicine—
Class of 1958
Pre-Med: Yale
Parent: Louis Singer

It was agreed that the next meeting of the Council would be held on February 17, 1955 and the meeting adjourned at 6:30 P. M.

Meetings Held During February

- February 1—Committee on Public Relations
- February 2—Conference on Retirement Plan
Committee on State Medical School
- February 3—Subcommittee on Toxemia
Subcommittee on School Health
AMEF Committee
- February 7—Woman's Auxiliary
- February 9—Advisory Committee to State Welfare
Department
Committee on Professional Relations
- February 10—Committee on Public Health
Committee on State Medical School
- February 16—Committee on Hospitals
Connecticut Medical Examining
Board
- February 17—Nominating Committee
Council
- February 28—Connecticut Health League

New Members

LITCHFIELD COUNTY

Donald E. Rowley, Winsted
Niel Russo, Thomaston

THE HISTORIAN'S NOTE BOOK

DR. WILLIAM BUCHAN AND HIS DOMESTIC MEDICINE

ALFRED LABENSKY, M.D., *New London*

The Author. *Chief of Staff and Chief Physician,
Lawrence and Memorial Associated Hospitals, New
London, Connecticut*

"I think the administration of medicines always doubtful, and often dangerous, and would much rather teach men how to avoid the necessity of using them than how they should be used."

At the time that this statement was made, in 1769, it was considered as rank heresy by most of the members of the medical profession, yet if one considers the pharmacopeia of that day it is no more than a statement of fact.

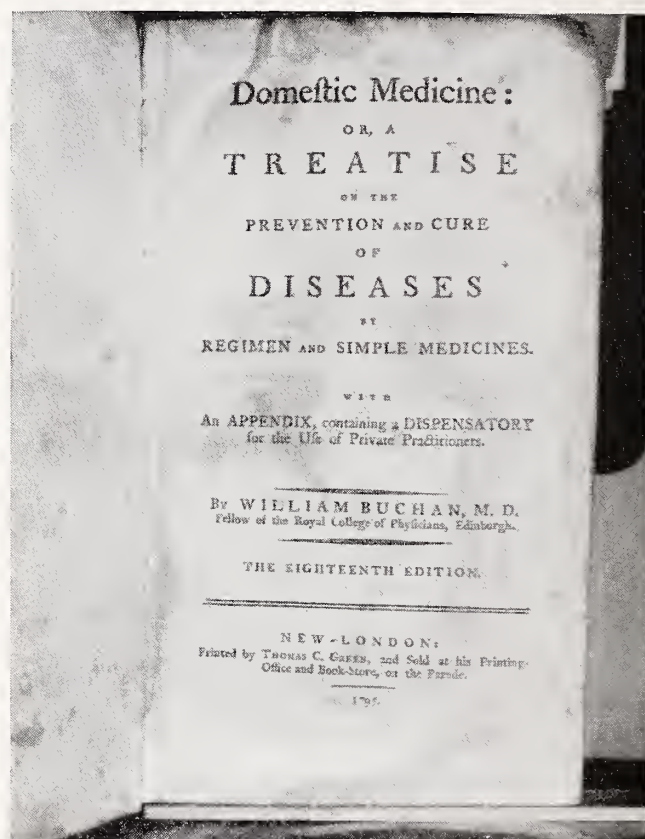
The author of the statement was Dr. William Buchan, who was born in Ancram, Roxburghshire, in 1720. While serving as a physician to a foundling hospital in Ackworth he became appalled at the fearful mortality among children and gave vent to his feelings in the following words: "It appears from the annual registers of the dead, that almost one-half of the children born in Great Britain die under twelve years of age. To many, indeed, this may appear a natural evil, but on examination, it will be found to be one of our own creating. Were the death of infants a natural evil, other animals would be as liable to die young as man; but this we find is by no means the case.

"It may seem strange that man, notwithstanding his superior reason, should fall so far short of other animals in the management of his young. But our surprise will soon cease if we consider that brutes, guided by instinct, never err in this respect; while man, trusting solely to art, is seldom right.

"Nor have physicians themselves been sufficiently attentive to the management of children: this is generally considered as the sole province of old women, while men of the first character in physic have refused to visit infants even when sick.

"It is really astonishing that so little attention should in general be paid to the preservation of

infants. What labour and expense are daily bestowed to prop an old tottering carcase for a few years, while thousands of those who might be useful in life, perish without being regarded! Mankind are too apt to value things according to their present, not their future usefulness.



"Cleanliness is not only agreeable to the eye, but tends greatly to preserve the health of children. It permits the perspiration, and, by that means, frees the body of superfluous humours, which, if retained, could not fail to occasion diseases. No mother or nurse can have any excuse for allowing a child to be dirty.

"It is strange how people came to think that the first thing given to a child should be drugs. This is the beginning with medicine by times and no wonder if they generally ended with it."

At the foundling hospital he put his theories into practice and by so doing reduced the mortality among children considerably. When the foundling hospital was closed in 1766, Dr. Buchan returned to Edinburgh where he practised successfully for many years. Feeling that the people in general should be taught something about medicine he published the first book for public education in medicine to appear in the English language in 1769. His purpose as he declared it was "that men of sense and learning should be so far acquainted with the general principles of medicine, as to be in a condition to derive from it some of those advantages with which it is fraught; and at the same time to guard themselves against the destructive Ignorance, Superstition, and Quackery. The most effectual way to destroy quackery in any art or science, is to diffuse the knowledge of it among mankind."

In his book he stressed the importance of cleanliness and general hygienic measures in preventing illness and curing disease. He advocated the use of public health laws to enforce cleanliness. "It is not sufficient that I be clean myself while the want of it in my neighbor affects my health as well as his own." . . . "Were every person, for example, after visiting the sick, handling a dead body, or touching anything that might convey infection, to wash before he went into company, or set down to eat, he would run less hazard either of catching the infection himself, or communicating it to others."

He had the temerity to criticize the doctors themselves: "There is reason to believe that infection is often conveyed from one place to another by the carelessness of the faculty themselves. Many physicians effect a familiar way of sitting upon the patient's bedside, and holding his arm for a considerable time. If the patient has the smallpox, or any other infectious disease, there is no doubt but the doctor's hands, clothes, etc., will carry away some of the infection, and, if he goes directly to visit another patient without washing his hands, changing his clothes, or being exposed to the open air, which is seldom the case, is it any wonder that he should carry the disease along with him? Physicians not only endanger others, but also themselves, by this practice. And indeed they sometimes suffer for their want of care."

His book met with instant success and the demand for it was so great that it ran through nineteen editions and was translated into every European lan-

guage. Eighty thousand copies were sold during his lifetime. The Empress of Russia sent him a gold medal and a letter of commendation. Many copies were sold in America and the copy in my possession was printed in New London in 1795. Financially he was not as successful as he sold the copyright for only seven hundred pounds, an amount which the publishers made each year from its sale.

As he anticipated in his preface, the publication was received with disfavor by most of his colleagues. One of his gentler critics, after describing Dr. Buchan as something a few degrees lower than a quack, said: "An author may compose a book of a domestic kind with very good intention. But the man who launches a book on the public, fraught with nothing but the encomiums on medicine of his own preparing, administering, and vending, may be truly branded as a disgraceful character."

In 1778 he removed to London where he had a considerable practice. His biographer says he practised regularly at the Chapter Coffee House. One wonders whether coffee houses sold beverages stronger than coffee, because the writer follows this statement by saying that he might have had a larger practice had it not been for his "convivial social habits." He was full of anecdote and was always good for a "touch."

At any rate he must have drunk good liquor for he lived to be 76. His health gave way one year before his death on February 25, 1805. He was buried in the cloisters of Westminster Abbey.

REFERENCES

- Domestic Medicine, William Buchan, M.D., F.R.C.P., Edinburgh.
Dictionary of National Biography, Brown-Chaloner, vol. III.

Medical Education Income for '54

Dr. Edward L. Turner, secretary-treasurer of the American Medical Education Foundation, reports that during 1954 the foundation received total income of \$1,182,627.08 from 22,996 contributors.

The foundation's income from July 1 through December 31 amounted to \$360,386.78, which is available for transfer to the National Fund for Medical Education for disbursement to the medical schools.

The 1954 records showed an increase of 4,820 contributors and \$92,664.15 over figures for 1953.

REPORT OF THE COMMISSION TO STUDY THE ESTABLISHMENT OF MEDICAL, DENTAL AND VETERINARY COLLEGES ON A NEW ENGLAND REGIONAL BASIS

SUMMARY OF FINDINGS

In July, 1953, with legislative authorization, you, as Governor, appointed this Commission to conduct a study of the establishment of medical, dental and veterinary colleges on a New England regional basis and to collaborate with commissions in other New England States conducting similar studies. Your Commission consists of two State senators, two members of the House of Representatives, one physician, one dentist, one veterinarian, the chairman of the board of trustees of the University of Connecticut, and one attorney as a representative of the general public.

Your Commission has held fourteen meetings in New Haven and one public hearing in Hartford. Members have participated in two regional workshop conferences held in Boston on October 9, 1953, and January 29, 1954. The Commission has received information and advice from various institutions and individuals qualified in the professional and educational fields involved, and from members of similar commissions created by other New England States. It has carefully reviewed the able presentations of former State commissions in the same general area.

The Commission is now prepared to make the following findings and general recommendations:

A

1. In the fields of medicine and dentistry, additional educational facilities are urgently needed.
2. A New England Regional approach would seem to be the best way to accomplish this objective.
3. The General Assembly should take steps to adopt a regional compact acceptable to other New England States, but such compact should assure representation of the Land Grant State Universities in each of the participating States on its governing body.
4. For the best advantage of Connecticut and other States in the area, the most practical method of putting a New England Regional Compact into operation would be for Connecticut to build its own Medical-Dental School, to be operated as part of

the University of Connecticut, in the City of Hartford.

By so doing, Connecticut (1) would acquire medical and dental personnel to fit the needs of its fast increasing population, (2) would afford adequate opportunities to qualified young men and women of its citizenry who wish to pursue these professions, (3) would retain appropriate control over a school which would obviously represent a substantial investment of its public money, and (4) would receive some financial assistance from other compacting States while offering citizens of these States a new and much needed field for the study of medicine and dentistry. Under the terms of a compact, contracting States would subsidize the difference between actual operating cost and the tuition paid by out-of-state students.

B

While the activation of a school of veterinary medicine to serve the New England area might seem a logical development, it appears that the need is not as urgent as in the case of medicine and dentistry.

HISTORICAL BACKGROUND

For the last decade there has been in Connecticut an increasing awareness of the need for expanded opportunity for the student who desires training in the health areas.

Our Commission has profited immeasurably from the explorations and reports of its predecessors in the field:

1. The Hartford County Medical Association "Committee to Study the Advisability of Establishing a Second Medical School in Connecticut," which reported in December, 1946 (CONNECTICUT STATE MEDICAL JOURNAL, vol. X, no. 12).
2. A special Committee "to inquire into the establishment of a School of Medicine at the University of Connecticut," which reported to the University Board of Trustees in January, 1947.
3. The Governor's Fact-Finding Commission on Education, which reported in June, 1950, ("Higher Education in Connecticut and Beyond").

4. The Governor's Commission on Health Resources, which reported on April 6, 1951.

5. The Governor's Commission on Medical Education, which published its report to Governor Lodge in March, 1953, (CONNECTICUT STATE MEDICAL JOURNAL, vol. XVII, no. 3).

The work of the earlier commissions has been so well summarized in the 1952 report of the Lodge Commission that repetition in this report appears unnecessary. Suffice it to say, that there has been a constant and lively interest in the need for increased training facilities in the medical fields, and the conclusions of the successive bodies show an increasing sense of the urgency of the problem confronting the Connecticut resident who desires to study medicine or dentistry.

APPRAISAL OF CURRENT NEED

There are very few completely objective yardsticks for measuring the need for new schools of medicine, dentistry and veterinary medicine. However, for both Connecticut and New England, certain general considerations present themselves:

1. THE RAPID POPULATION GROWTH OF THE STATE AND REGION

Which is expected to continue at an accelerated rate:

It should be noted that Connecticut will have a

larger population to seek health services, and the World War II crop of babies will be knocking at the doors of professional schools within the current decade.

2. THE HIGH INCOME LEVEL OF CONNECTICUT AND NEW ENGLAND

TABLE II
RANK OF NEW ENGLAND STATES AMONG ALL STATES OF THE NATION

	PER FAMILY INCOME*		PER CAPITA INCOME†	
	RANK		RANK	
Connecticut	4	(\$3,155)	3	(\$2,080)
Maine	34	(\$2,213)	31	(\$1,361)
Massachusetts	13	(\$2,909)	12	(\$1,749)
New Hampshire	26	(\$2,405)	25	(\$1,530)
Rhode Island	22	(\$2,650)	18	(\$1,655)
Vermont	37	(\$2,101)	32	(\$1,336)
For the Nation.....		(\$2,619)		(\$1,639)

*From Statistical Abstracts of U. S.—1953. U. S. Department of Commerce, Washington, D. C.

†From Economic Almanac 1953-54—National Industrial Conference Board, October, 1953.

Since there is a direct correlation between ability to pay and demand for health services, this indicates that Connecticut is able to support many more medical practitioners in proportion to its population than even our New England neighbors.

TABLE I
NEW ENGLAND POPULATION

January, 1954

STATE	TOTAL CIVILIAN POPULATION			PER CENT CHANGE 1940-52	PER CENT CHANGE 1950-52	ESTIMATED POPULATION 1960	ESTIMATED PER CENT 1940-60
	1940	APRIL 1950	JULY 1952				
Maine	847,000	912,000	883,000	4.3	—3.1	1,055,000	24.6
New Hampshire	492,000	531,000	528,000	7.3	—0.6	616,000	25.2
Vermont	359,000	378,000	369,000	2.8	—2.2	421,000	17.3
Massachusetts	4,317,000	4,665,000	4,695,000	8.8	.6	5,359,000	24.1
Rhode Island	713,000	774,000	782,000	9.7	1.0	892,000	25.1
Connecticut	1,709,000	2,001,000	2,100,000	22.9	4.9	2,417,000	41.4
Total	8,437,000	9,261,000	9,357,000	10.9	1.0	10,760,000	27.5

Source: Current Population Report, Population Estimates—Series P-25, No. 56, January 27, 1952; No. 87, December 28, 1953.

3. THE ANTICIPATED INCREASE IN COLLEGE AND PROFESSIONAL SCHOOL MATERIAL BETWEEN NOW AND 1970

TABLE III
INCREASE IN ESTIMATED COLLEGE AGE POPULATION

	PERCENTAGE INCREASE OVER 1953		
	1960	1965	1970
Connecticut	27	71	85
Maine	2	25	36
Massachusetts	9	38	52
New Hampshire	10	34	55
Rhode Island	12	49	67
Vermont	8	25	40
Average for the Nation.....	16	46	70

Here again Connecticut is well above the New England and the national average.

4. THE EDUCATIONAL LEVEL OF CONNECTICUT AND NEW ENGLAND

Connecticut is presently not meeting the post-secondary school needs of Connecticut youth.

A. The State of Connecticut now ranks forty-fourth lowest in the percentage of its own high school graduates attending college within the borders of its own State (enrolled in both public and private institutions).*

B. Forty-five per cent of Connecticut youth going to college attend colleges outside the State; Connecticut, therefore, ranks fourth highest among the forty-eight states in the percentage of its own high school graduates going to college outside the State. Of those going outside the State, 16.4 per cent attend State colleges or State universities in other states.*

5. THE OBLIGATION OF THE STATE TO MEET DEMONSTRABLE NEEDS

In each of the three areas under study there is a threefold obligation to be measured in two time dimensions, present and future. All of these must be considered in any attempt to assess the need: (a) the obligation to the citizens to meet growing health needs; (b) the obligation to a growing body of qualified Connecticut students to provide the type of training they require; and (c) the obligation to contribute our share to the national pool of the technically trained.

*Source: "Residence and Migration of College Students, 1949-50" by Federal Security Agency, United States Office of Education, 1951.

THE NEED IN THE MEDICAL FIELD
OBLIGATION TO THE GENERAL PUBLIC

The 1952 Commission Report quoted figures to demonstrate that Connecticut stood fifth among the States and the District of Columbia in the number of active nonfederal physicians per 100,000 population, and figures collected since indicate that Connecticut still maintains a very high relative position with regard to the number of physicians available to its population. While these figures do not take into account the physicians who are specialists, employed full time in education or industry or otherwise unavailable for general practice, we must still conclude that, if the country as a whole has enough physicians for its population (and we lead all major nations in this respect), so does Connecticut.

Two other questions, however, arise in this area. Even at present does Connecticut have enough physicians to provide the service her people desire and can pay for, or perhaps more important, to supply medical service at a reasonable cost? Many experts feel the United States as a whole faces a very real manpower shortage in health services. What of the future with our growing population?

OBLIGATION TO THE PROSPECTIVE STUDENT

States have increasingly recognized the obligation to provide from tax funds the kind of training desired by various age groups in the population. This obligation has become axiomatic and has found expression in everything from nursery schools to adult education programs.

The Commission has found that under existing conditions Connecticut students do not have opportunity equal to that of students in the country as a whole to attend medical school. Because nearly all State supported medical schools (there are 34 in 32 states) give an over-all preference to their own State residents, and regional agreements, such as those in effect in the South and West, are closing these areas to New England applicants, this situation is likely to grow worse. The New England applicant cannot rely on existing New England schools: there is only one small, State supported medical school (University of Vermont) and, of the remaining four medical schools, two (Yale and Harvard) accept students on a national basis. Places for Connecticut students are becoming scarcer.

Figures on the entering medical classes of the last four years at all United States and Canadian schools

have shown Connecticut below the national average on the percentage of applicants who are accepted. In the 1952 class, the State ranked at the bottom of the 48 States with only the District of Columbia below her. In 1953, Connecticut had risen to the dubious honor of 44th place.

It is suggested that tables from the *Journal of Medical Education*, February, 1953 including national averages, be referred to. These tables show a high correlation between the presence of a State supported medical school and a high acceptance rate.

Several factors may be said to qualify these data: The number of Connecticut students attending medical school outside North America; the number of qualified students who never applied because of the expense of applications and the known difficulty of being admitted.

Nevertheless, the over-all picture seems to be one of increasing difficulty for the Connecticut applicant to medical school.

OBLIGATION TO THE NATION'S POOL OF PHYSICIANS

Because of her relatively high standard of living, Connecticut is attractive as a place to practice medicine. Figures indicate that each year 60 per cent more physicians establish practice in Connecticut than there are Connecticut residents graduating from medical school. Thus this is a heavy importing State. Geographic mobility of physicians is a healthy thing, and there would be no need for concern if we were sending approximately equal numbers of Connecticut physicians to practice in other areas.

Historically, Connecticut has been proud of its leadership in education fields, and there have been objections here to federal taxation for building services in backward areas. Yet, in the important field of medical training we are not making our proportionate contribution to the national pool.

THE NEED IN THE DENTAL FIELD

OBLIGATION TO THE GENERAL PUBLIC

In the dental field, the immediate need for trained personnel is more urgent than in the medical. During the period 1940-50, the number of dentists in proportion to population decreased steadily throughout New England. In spite of this, in 1952 Connecticut stood fifth in the United States in number of dentists per 100,000 population.

The present ratio is estimated at one dentist for every 1,368 people. Since repeated surveys have

shown New England to have a high prevalence of dental defects, an ideal standard of health for the civilian population could be attained with a ratio of approximately one dentist for every thousand people.

For the future we have the replacement problem. We are now gaining dentists to the extent of about fifty to seventy-five per year, but losing almost as many through death and retirement. If the average age of Connecticut dentists is anywhere near the New England average of over fifty years, we have a convincing picture of need to train dentists for the future.

OBLIGATION TO THE PROSPECTIVE STUDENT

For the student who desires to study dentistry, the limitations being imposed by regional admissions policies work very much as they do for the medical hopeful. The following data, supplied by the American Dental Association, give some insight into the problem:

TABLE IV
PARTICIPANTS IN THE 1952 DENTAL APTITUDE TESTING PROGRAM
NOT ADMITTED TO DENTAL SCHOOLS IN 1952

STATE	NUMBER		REMAINDER	NUMBER OF REMAINDER WITH AVERAGE OR HIGHER APTITUDE TEST SCORES
	NOT ACCEPTED IN 1952	NUMBER ACCEPTED IN 1953		
Connecticut	42	7	35	10
Maine	8	1	7	2
Massachusetts	73	14	59	15
New Hampshire	7	2	5	2
Rhode Island	14	0	14	2
Vermont	6	1	5	0

TABLE V
RESIDENTS OF NEW ENGLAND STATES PARTICIPATING IN THE 1951,
1952, AND 1953 DENTAL APTITUDE TESTING PROGRAM ACCEPTED
BY ANY DENTAL SCHOOL IN ANY YEAR

STATE	TOTAL ACCEPTED	TOTAL PARTICIPATING	PER CENT ACCEPTED
Connecticut	163	316	51.58
Maine	32	51	62.75
Massachusetts	290	527	55.03
New Hampshire	31	56	55.35
Rhode Island	45	89	50.56
Vermont	19	33	57.57
Total	580	1,072	54.10

Table IV demonstrates that there is annually a group which appears qualified on the basis of the one objective criterion available—the Dental Aptitude Test—which does not gain admission to any school. While this group is not demonstrably large enough to fill an entering class of a new dental college, a more readily available training facility would undoubtedly bring a larger group of qualified recruits from Connecticut, and surely from the rest of New England. The future needs of the State seem to warrant some action in the field.

THE NEED IN THE VETERINARY FIELD

OBLIGATION TO THE GENERAL PUBLIC

Connecticut has 0.9 per cent of the total veterinary population of the United States. Despite the absence of any training center in New England, Connecticut had 1.1 per cent of the total entering class of veterinary students in 1953. Based on a study of Connecticut and New England youth attending veterinary colleges during the four year period, 1950-1953 and 1951-1954 inclusive, it was noted that Connecticut had 0.7 per cent - 0.75 per cent of all the veterinary students enrolled during that time. This percentage represents more than a sufficient number to meet the requirements of practice within the State, but is slightly deficient (0.15 per cent) in maintaining its overall position and in contributing to the national pool. Since the average age of all the practicing veterinarians in Connecticut is now 39.45 years (lowest in New England), continuation of student admissions at this rate should supply needed replacements. The decreasing farm acreage and the static cattle population in Connecticut seemingly indicate no expanding need in the large animal field. We cannot, however, get a complete picture of the needs for veterinary service by considering only the farm aspects of the problem. With an apparent human population increase projected for this State, it must be stated that there might be a slight increase in demands for veterinary service in the small animal field.

OBLIGATION TO THE PROSPECTIVE STUDENT

Statistics based on admissions during the four-year period, 1950-1953, would seem to indicate that the other New England States were slightly deficient in the number of students attending veterinary colleges. However, the actual veterinary student enrollment for the six New England States has increased annually and in 1953 the total entering freshman class contained 3.01 per cent of New

England students; this is in contrast with 3.7 per cent veterinary population for the New England area. If the present trend continues (1950-1953), it would be reasonable to assume that not only the basic requirements of practice would be met and maintained but New England would be contributing to the national pool.

The Commission has concluded that in terms of the needs of Connecticut students for advanced training, and the future needs for service in the State, the expansion of medical and dental facilities should take priority.

MEDICAL AND DENTAL TRAINING—METHOD OF MEETING NEED

NEW ENGLAND HIGHER EDUCATION COMPACT

Permissive legislation has been enacted in Washington recently which, upon ratification by the Legislatures of the New England States, would provide for the creation of a New England Board of Higher Education. Each State would have three representatives on the Board. It is expected the Board would operate in much the manner of the boards under the Southern Regional Compact and the Western Regional Compact, as a clearing house through which States could purchase education in professional fields from both public and private institutions in any of the six States.

Under the Compact, the Board would be an instrumentality for study of educational problems on a regional basis and publication of its findings. It is expected that institutions would agree to accept a specified number of qualified students from each of the New England States, and the home State would agree to subsidize the difference between tuition and cost of education of its students accepted by institutions in other States. The Compact assumes the willingness of existing institutions to increase enrollments or expand facilities. However, under the Compact, the Board has no power to create new facilities.

The principle of joint action by the New England States is a good one. This Commission feels that the Compact is only a partial answer and that supplemental action is indicated.

In 1948 the land grant universities of the six New England States formed a New England Educational Council to develop a cooperative program to improve higher education in this area. A number of constructive agreements have resulted in the fields of law, forestry, social work, insurance, physical

therapy and pharmacy, to name a few. In view of this experience, the Commission believes that the land grant universities should be represented on the New England Board of Higher Education.

There is some doubt as to the ability and willingness of existing institutions to expand their facilities on the promise that for two years a subsidy of approximately \$2,000 annually per student would be provided. In the case of Connecticut, there is no dental school and only one privately controlled medical school, that of Yale University. Only recently Yale expanded its medical classes by 33⅓ per cent and it is unlikely to expand further on its own resources. Moreover, while there is a precedent for State purchase of training service from private institutions, and Yale officials desire to cooperate with the State, there are many considerations which would make cooperation difficult. These have been explored in the 1952 report. Chief among them are the relationship between public administrators of public funds and the private university; the need for additional clinical facilities in New Haven; and the quite commendable Yale policy of admitting the best qualified applicants on a national basis.

CREATION OF A NEW REGIONAL FACILITY

The Commission believes that the establishment of a new facility, which would accept a substantial number of New England applicants on a contract basis under the auspices of the New England Higher Education Board, is the most practical method of providing opportunity for Connecticut students.

There are three cities in all New England which are at the same time without a medical school and large enough to supply the clinical facilities needed: Hartford, Providence and Springfield.

Location of a regional medical-dental school in Hartford would make available to that area free clinic facilities which might reduce considerably the cost of medical service which the State Welfare Department meets annually. The services of one small State medical school, when calculated on the basis of Veterans Administration rates, were found to be very close to the operating deficit of the medical school.

Thus the State in which a regional medical school is located could actually be shown to regain some of the operating cost, though none of the capital expenditure.

CONSTRUCTION OF A STATE-SUPPORTED MEDICAL-DENTAL SCHOOL IN CONNECTICUT

This has been under discussion for the past decade. It has been suggested that, even under the New England Compact, Connecticut should take the initiative and create its own medical-dental school, to which students from other New England States could be admitted on either a contract or a higher tuition basis.

The Commission feels that construction here is practical in view of our rapidly increasing population, the prospect of imminent greatly increased demand for educational opportunity, and the time which will elapse between authorization and operation. We believe the need sufficiently great to warrant a large expenditure of public funds.

The University of Buffalo constructed and equipped such a combined school, which was completed in 1953, for 100 medical and 80 dental students per year, at a cost of \$4,500,000. To this figure, Connecticut would have to add the cost of site acquisition since the University of Buffalo was able to build on its own land.

It is our understanding that the Hartford hospitals are willing to cooperate if a State medical school should be located in Hartford. On the assumption that such a school could be built in Hartford to use the clinical facilities of Hartford hospitals, we believe the capital expenditure could be placed between five and six million dollars.* Annual operating expense, based on experience of similar schools, would run approximately \$700,000 for medical school and \$300,000 for the dental school.

*Costs vary widely depending on sizes of classes, available facilities and program contemplated. According to the AMA, where hospital facilities are available which can be integrated into a medical school program, basic science teaching and research facilities, clinical research laboratories and teaching areas could be established, depending on sizes of classes, for approximately \$5,000,000.

National Hospital Week — May 8-14, 1955

The public relations directors of member hospitals are starting now to make plans for National Hospital Week. The theme for 1955 is "Your Hospital—A Tradition of Service." This theme emphasizes the continuing service each hospital offers its community and adapts well to existing local programs.

OUR MEDICAL WORLD

Members of the Guatemalan Medical Association have recently been cleared, according to the *New York Times*, of accusations that they participated in the alleged police tortures and murders during the last days of the Jacolo Arbenz Guzman regime in June 1954. Public charges were made that some physicians had suggested torture methods, participated in atrocities, and had lied about the effects of torture on some persons when ordered by the courts to examine them during habeas corpus proceedings.

A secret investigation of these charges was carried out by the Association's Executive Committee. The final report said that all members of the Association had acted "with honesty and integrity" and had adjusted their conduct to the principles of "dignity, truth and decorum" in the revolution.

Even at this great distance, these charges have a familiar fabricated ring that suggests their origin from Communist sources. Unfortunately the misguided German physicians, who participated in the infamous Gestapo experiments, and were subsequently tried and condemned, have made it possible today to believe this sort of lie. The Reds have proved their ability to take advantage of such possibilities.

Physicians in this country have long enjoyed a sort of immunity from severe criticism in the public press, and have more recently learned what it is like to be branded as fee-splitters, price gougers, night-call dodgers, and even worse. At least we can be thankful that we are so far spared the epithet of torturer and murderer.

The membership of the Guatemalan Medical Association should be congratulated for their courage, discretion and promptitude in the investigation of these unsavory accusations, and for their strongly worded final report.

* * * *

Private enterprise in the construction of new hospital facilities is not entirely a thing of the past in Europe. A three-story, twenty-one bed, modern hospital has just opened in Madrid's University City. It was constructed primarily to serve the needs of the growing British-American community, but has had the full support of the Spanish people and their

government. The government donated the old German hospital, which was sold for \$44,000, the Ministry of Education gave the new hospital seven thousand square yards of land free of charge for fifty years, and the Ministry of Commerce granted free import permits for equipment that was purchased abroad.

Seventy per cent of the contributions have come from United States concerns and citizens with the rest from Britons and Spaniards. The equivalent of \$225,000 has been spent so far, but this has barely met the cost of building and equipment. At least \$10,000 must be raised next year for maintenance, nurses' salaries, replacing equipment, and other expenses. A generator costing \$3,500 will have to be installed to insure a constant flow of electricity to the hospital, because prolonged drought has forced the imposition of severe curbs on the use of light in Madrid during the day time hours.

Among the stated objectives of the new institution are to provide first class nursing facilities at a cost within the means of all patients and to offer an opportunity for an interchange of medical knowledge and technique between the Spanish and the foreign medical professions.

Cost to the patient will certainly be most reasonable according to experience in this country and will be among the lowest in western Europe. Single room with bath will cost the equivalent of \$7 daily including meals and ordinary nursing care. A double room will cost \$6 a person.

The well known American Hospital in Paris provides a successful precedent, if one is needed for this type of service. It will be a source of satisfaction to the increasing number of American tourists who visit Spain each year to realize that this modern facility is available for their emergency treatment if required in surroundings which will be reminiscent of home. It should provide a further stimulus to cooperation in medical studies and hospital care between doctors in Spain and in Great Britain and the United States. At the same time, it emphasizes the increasing interest and participation in affairs in Spain, which has come about on the part of this country since the conclusion of World War II.

* * * *

In the last month of 1954, we were treated to the disheartening spectacle of a strike of physicians in Brazil. Government hospitals and laborer's free-care institutes, sponsored by the government, provide a sizeable amount of the medical treatment offered in that country, particularly in Rio de Janeiro. The government employs approximately 15,000 physicians on a full- or part-time basis at comparatively small salaries.

Many of these physicians supplement their salaries by income from private practice, which they maintain on the side. The serious inflation, which has taken place in Brazil since the end of World War II, has driven more and more patients from the working class to the free-care centers. The hard-pressed physicians succeeded in persuading Congress to pass a bill granting a 25 to 30 per cent rise in the minimum wage for all physicians holding university degrees. Because this would have added over \$14,000,000 annually to the already overstrained budget, the bill was vetoed by Brazil's new president, Café Filho.

As a gesture of protest, the Brazilian Medical Association called a general doctor's strike for December 6, a few days before Congress was to meet and act on the veto. In Rio alone some 600 doctors struck, closing the government's hospitals and free-care clinics. The president declared the strike illegal, banned picketing, sent military doctors to work in civilian hospitals, fired the 210 department heads among the strikers, and then appealed to the strikers over the radio. When the strike had lasted four days, he summoned strikers to the presidential palace and promised to try to help them financially, if they would return to work. They were threatened with draft into the army, if they did not return. The doctors then voted to end the strike, but the government would not restore the department heads to their jobs. Two days later Congress met and upheld the president's veto by failing to obtain a two-thirds majority against it.

Unhappily for the prestige of medicine in Brazil and around the world, the president of the Brazilian Medical Association was one of eight doctors jailed for picketing hospitals. If there are any further doubts about the ability of private medical practice to survive in the face of government sponsored free medical care, they should be dispelled by this unedifying experience.

* * * *

When the chief medical officer of the Ministry of Health of Great Britain, Sir John Charles, made his report for the year 1953 recently, he stated that Britain's health, as reflected in the basic statistics, showed signs of becoming stabilized. He went so far as to suggest that the gains likely to be attained by present means of improving health have been almost fully achieved. This rather surprisingly optimistic viewpoint is not reflected in other news of developments in medical services in that country during the past year.

The House of Commons Public Accounts Committee criticized expenditures of the National Health Service in spite of its report that it expects to have saved \$84,000,000 on the costs of its medical, pharmaceutical, dental and ophthalmic services in the past year. Administrative costs have been reduced to about twelve cents per person, and payments by patients for medicines, appliances, eye glasses, and dental treatments have helped to reduce costs to the government. On the other hand, allowances to druggists to cover risks of unpaid charges on prescriptions, estimated at \$476,000 a year, have apparently been unjustifiably paid without production of sufficient evidence to judge actual losses. For the same ingredients, Scottish druggists were paid more on the average than English druggists. There was a continued failure by some hospitals to prepare and maintain inventories, although appreciable losses of bedding and linen had occurred.

The Accounts Committee also pointed out that out of 31 hospitals bought by hospital boards since the initiation of the National Service, 14 have been unused for two years, and 9 for twelve months. Five of the 14 are now being sold. This has occurred in the face of a severe shortage of active hospital beds. An example of the bureaucratic difficulties which impede hospital services occurred at St. Mary's Hospital in Portsmouth, which has a waiting list of over 1,000 surgical patients. Two new operating rooms costing \$140,000 were opened a few months ago to supplement the one already in use. Only two rooms are now functioning, however, since the hospital's allocation was cut \$84,000 by the regional hospital board, forcing the management committee to cut the staff. The Ministry of Health denies knowledge of any application for additional staff, although it was made by the hospital management committee to the board.

At the Labour Party Annual Conference at Scarborough, speakers asserted that an administrative

empire was being built up at the expense of hospitals, that nurses were leaving in large numbers because of insufficient auxiliary help, and that the cream of hospital staffs was leaving because of inadequate pay. The Labour Party executive served notice that when and if they return to power, the small number of pay beds in national service hospitals will be discontinued. In spite of the facts that the charges for the use of these beds are 25 per cent over cost, and that the cost has risen from \$20 to \$25 a week in 1948 to \$42 to \$100 a week at present, there is still quite a large number of people who prefer to be treated as private patients. The Minister of Health has criticized this pledge as hypocritical and irrelevant to the problems of National Health Service.

Citation to Dr. Warnshuis



Dr. Lilian Warnshuis, physician at Connecticut College, New London, was honored on Sunday, January 23, as one of three women physicians in the United States to receive the 1955 Elizabeth Blackwell Citation for "her outstanding contribution in the field of Internal Medicine." Dr. Warnshuis was also chosen to make the acceptance speech for this year's winners at the ceremony in the new building of the New York Infirmary, New York City. President Millicent Carey McIntosh of Barnard College gave the main address.

Dr. Warnshuis, native of Inverness, Scotland, received her medical education at the Edinburgh

Medical University. She has been on the staffs of a number of hospitals, many of them in India where she practiced from 1913 to 1924. In this country she has served on the staffs of the New York University-Bellevue Hospital and its Medical School, the Staten Island Hospital and the Wagner College Nursing School. Dr. Warnshuis joined the faculty of Connecticut College in 1949 as College Physician where she was instrumental in planning details and equipment for the college Infirmary which opened to its first student-patient in September 1951.

The citation received by Dr. Warnshuis is named in honor of Elizabeth Blackwell, the first woman to receive a medical degree from an American college, and founder of the New York Infirmary in 1853. Mrs. Frank A. Vanderlip, president of the New York Infirmary, presented the awards and Mrs. Frank Altschul, chairman of the Citations Committee, introduced the candidates: Dr. Katherine Dodge Brownell of New York City, cited for her work in pediatrics and public health; Dr. Phyllis Greenacre of New York City, named in psychiatry; and Dr. Warnshuis of New London for work in internal medicine.

Dr. Warnshuis, now an American citizen, lives in New London with her husband, the Reverend John R. Warnshuis, D.D. They have two daughters, Joan and Lois, both married; Joan with three daughters and Lois with two daughters.

Dr. Warnshuis is the author of *Medical Clinics of North America* and of *Hodgkins Disease of Thyroid Gland*. She is the author of an article, "A College Physician Reports," in the January 1955 issue of the *Richmond County (New York) Medical Society Bulletin*. She is a member of medical societies including the Women's International Medical Society, the American Medical Association and the Society for Study of Internal Secretions.

Stamford Physicians Set Fine Example

In the *Stamford Advocate* recently there appeared a letter from a layman congratulating the Stamford physicians on the fact that 66 of their number had signed up for the Red Cross blood donation program. "This is a wonderful and inspiring example for all of us," writes this layman. "The public is probably little aware of the great amount of free time that the doctors give at the various clinics throughout the year. The giving of blood is another example of their devotion and sacrifices."

NEWS FROM WASHINGTON

Status of Major Administration Health Bills

Most major Administration bills have been introduced in Senate or House. S886 and HR3458, identical bills, provide for reinsurance, mortgage insurance, traineeships of nurses and other professional personnel, revision of the public health grants and a bigger mental health program. Other bills include S890 and HR3426 to extend the water pollution control program, HR3292 to improve grants for mothers, crippled children, etc., HR3293 for better medical care for the indigent, S894 for a new attack on juvenile delinquency, HR2685 for medical care of military dependents and HR2886 to extend the doctor draft.

Hill, Bridges and Priest

Senators Lister Hill (D—Alabama) and Styles Bridges (R—New Hampshire) are cosponsoring S849, which authorizes \$30 million annually for three years to stimulate building, modernization and equipping of laboratories in professional schools, hospitals and other nonprofit institutions. Companion bill in House is HR3459, introduced by Rep. J. Percy Priest (D—Tennessee). Chances of passage are good: Hill and Priest are chairmen of the respective committees that will consider plan; Hill and Bridges are influential members of Senate Appropriations Committee, which would pass on money allocation.

Schools of medicine, dentistry and osteopathy are specifically mentioned in the bill as prospective beneficiaries. For funds distribution purposes, country would be divided into four regions, each to receive almost equal amounts annually. Grants could be up to 50 per cent of the project's total cost.

In the late 1940's, Congress appropriated several million dollars for construction of heart and cancer research facilities. Outbreak of the Korean conflict terminated this assistance. Hill-Bridges-Priest bill's purpose is to fortify statutory sanction and clarify objective of research support for all chronic and killing diseases, and not just heart disease and cancer. President's budget for 1955-56 makes no allotment for research construction assistance.

Medical School Grants

Rep. M. G. Burnside (D—West Virginia) has revived his \$300 million, 5 year plan to give government a role in construction of new medical schools and improvement of existing ones. His HR3297 is identical to his HR2152 of 1951. One-half of the \$300 million would be apportioned among qualified institutions of learning in the health professions, including teaching hospitals and dental schools, as well as medical colleges.

Purtell's New Measure

Little different in substance from Title VI of GOP omnibus health bill is S848, filed by Senator William A. Purtell (R—Connecticut). This measure, as its sponsor said, grants no new authority but emphasizes that "mental health projects, especially in basic mental health research, the training of professional personnel and grants to the States for mental health purposes, are to be given special recognition for a reasonable period of time."

Health Message Appeals to Congress for Passage of Bills

Except for his request for a bigger U. S. contribution to World Health Organization, President Eisenhower's special health message on January 31 carried no recommendations that had not been made earlier in his state of the union or budget messages. The health message did, however, give the President an opportunity to explain to Congress why he thought his suggestions should be enacted this year. Some of the President's remarks, and the basic outline of the programs he is proposing, follow:

REINSURANCE

The Administration wants Congress to appropriate \$25 million to start a federal reinsurance fund for the use of voluntary health insurance groups. The President said reinsurance would be most helpful in three broad areas: (a) with rural families, (b) to expand catastrophic insurance, and (c) to bring protection to low income families in the form of coverage for home and office calls as well as hospitalization. Last year the House defeated a rein-

surance bill that followed the same lines but that did not pinpoint particular areas. In urging passage of the reinsurance bill the President said in part:

"A great many people who are not now covered can be given (insurance) protection. . . . A federal health reinsurance service (would) encourage private health insurance organizations in offering broader benefits to insured individuals and families and coverage to more people."

Administration's new reinsurance plan is broader and more specific than last year's version. It would stimulate health insurance coverage of expenses for home and office medical care, a daring wrinkle. Capitalization of the reinsurance fund is set at \$100 million, instead of \$25 million (WRMS predicted this increase several months ago). Provision is made for a 12 member advisory council to Secretary of Health, Education and Welfare, who would be charged with responsibility for plan's operation. The bill spells out minimum benefits for major medical expense insurance. One of its objectives is coverage of farm families.

MEDICAL CARE FOR INDIGENTS

The President described the present medical care program for public assistance recipients as "far from adequate." He proposes \$20 million more in U. S. appropriations, to be matched by the States and placed in a separate fund exclusively for medical care payments. (This fiscal year the U. S. is spending about \$80 million in this field.)

MORTGAGE GUARANTEE

The Administration is offering an amended version of last year's Kaiser-Wolverton bill for U. S. guarantee of private loans for health facilities. The President said:

"Present methods of financing are not always satisfactory in meeting this problem. Many sponsors and operators are unable to qualify for grants under the recently extended hospital survey and construction act (Hill-Burton). Sponsors of health facilities often find it difficult to obtain private capital for construction."

HEALTH PERSONNEL

Three methods are proposed to increase the supply of trained personnel, (a) grants to States for training practical nurses, (b) Public Health traineeships for graduate nurses in specialty nursing fields, and (c) establishment of PHS traineeships in public

health specialties, including mental health. On this Mr. Eisenhower said:

"Whether we look at health problems in terms of service for the community or for the individual—at problems of research, prevention or treatment of disease—we find that supplies of trained personnel are critically short."

MENTAL HEALTH

Three approaches recommended, (a) more aid to States and communities, (b) more money to train personnel for care of mental patients under present authorizations, (c) a new program of project grants aimed at improving the quality of care in institutions and searching out ways of reducing length of stays. The latter point is in recognition of the fact that the care of mental patients is the heaviest financial burden in the medical fields for most States.

Three Commissions Proposed

In February, Congressional bills were introduced for establishment of three more Federal commissions—on problems of mental health, on nursing services and on programs for the aging population. Their respective sponsors are Senator William Purtell (Connecticut), Rep. Frances P. Bolton (Ohio) and Senator Irving Ives (New York), all Republicans. Rep. Melvin Laird (R-Wisconsin) also introduced a bill to set up a commission on aging.

Purtell bill (S724) creates an 18 member group, all appointed by the President, to conduct "a thorough inquiry" into mental illness from all aspects—adequacy of treatment facilities, availability of professional personnel, research, etc.

More than 15 national organizations (two of them governmental) are cooperating in this venture. Its initial backing (\$5,000) comes from Field Foundation.

The new Bolton plan (H.J.Res. 171) calls for a 12 member commission to gather information on training and utilization of nurses. Four members each would be appointed by President, Vice-President and Speaker of the House.

Senator Ives' bill (S658) is similar to one he introduced last year. It provides for a 25 member commission, consisting of Secretary of Health, Education and Welfare; 14 named by President, and five each by the Vice-President and House Speaker. It would be a fact-finding body, concerning itself with institutional facilities, care of the chronically ill,

recreation opportunities and economic problems of senior citizens.

✓ Ives-Flanders-Case Bill S434

Three "progressive moderate" Senate Republicans, Ives (New York), Flanders (Vermont), and Case (New Jersey), introduced a bill for Federal support of nonprofit health prepayment plans (introduced previously in House). The omnibus measure also provides for a continuing health study by a bipartisan commission, further expansion of Hill-Burton hospital program, subsidies for medical and nursing schools, and increased public health assistance to the States.

More Bills

In February there were introduced numerous measures illustrative of mounting rivalry in field of health legislation. Rep. John Dingell (D—Michigan) reintroduced his bill (HR2384) for Federal hospitalization of the aged. Rep. Charles A. Wolverton (R—New Jersey) again filed the reinsurance bill (HR2533) in form in which House Commerce Committee approved it last year (but not the 1955 version. Rep. Frances P. Bolton (R—Ohio) introduced HR2559, to permit commissioning of men in military nurse corps. Rep. Mendel Rivers (D—South Carolina) put in a bill (HR2436) on medical care of servicemen's dependents.

✓ Wolverton Explains Bills

Former Chairman Charles A. Wolverton (R—New Jersey) of House Commerce Committee published a statement in Congressional Record (January 11) explaining purposes of the seven health bills he introduced on opening day of Congress. HR397 and 398 authorize Federal mortgage loan insurance to encourage construction and expansion of hospitals and prepayment clinics (latter bill corresponds to his HR7700 in previous Congress). HR399 provides for government loans to health associations and is same as HR6950 in 1954. HR400 and 401 are on Federal reinsurance of voluntary health prepayment plans. HR402 makes income tax concessions to members of prepaid health plans. HR403 is a revival of the Administration sponsored HR7397 of last year on block grants to the States for public health assistance, a bill that passed House but died in Senate.

Two Physicians Named to Advisory Group on Rehabilitation

National Advisory Council on Vocational Rehabilitation, just appointed by Secretary of HEW Oveta Culp Hobby, includes two physicians among its 12 members. They are Drs. Henry H. Kessler, orthopedic surgeon and director of Kessler Institute for Rehabilitation at West Orange, New Jersey, and Theodore G. Klumpp, president of Winthrop-Stearns, Inc., chairman of Hoover Commission's medical task force, and a member of the Connecticut State Medical Society. Miss Mary E. Switzer, director of Office of Vocational Rehabilitation, will serve as council chairman.

Connecticut Congressmen on Committees

Senator William A. Purtell (R), of Hartford, will continue to watch over the health problems of the nation as an important member of the Senate Labor and Public Welfare Committee of the 84th Congress. This committee, of which Senator Lister Hill (D) of Alabama is chairman, has jurisdiction over most health bills, including reinsurance and veterans hospitalization.

In the House, Representative Albert W. Cretella (R), of North Haven, is a member of the Post Office and Civil Service Committee which handles bills affecting civilian employees of the federal government. His committee will have major influence on the outcome of the administration sponsored contributory health insurance plan for federal employees. Representative Antoni N. Sadlak (R) of Rockville is a member of the Ways and Means Committee which has jurisdiction over Social Security, taxation and finances. Thomas J. Dodd (D) of Windsor and Albert P. Morano (R) of Greenwich are members of the Foreign Affairs Committee which handles proposed constitutional amendments, including Bricker amendments.

Admiral Boone Retires

Vice-Admiral Joel T. Boone (MC), U. S. Navy, Rtd., has retired as Chief Medical Director of V.A. Dr. William S. Middleton, dean of the University of Wisconsin Medical School since 1935 succeeded Admiral Boone on March 1, 1955.

Dr. Middleton, an overseas veteran of both World Wars, has been associated with the veterans medical program in a variety of part-time consultative capac-

ities dating back to 1922 when he served the United States Veterans Bureau as an attending specialist in tuberculosis.

He was one of the original members of the VA Special Medical Advisory Group established by law soon after World War II to advise the VA Administrator and Chief Medical Director in regard to the care and treatment of disabled veterans. It was this group that was instrumental in establishing the association between the VA and leading medical schools of the nation. At the present time Dr. Middleton is a member of the national VA medical Advisory Committee on Education, and chairman of the Dean's Committee affiliated with the Madison, Wisconsin, VA Hospital.

LETTERS TO THE EDITOR

The Adoption Procedure

February 9, 1955

To the Editor:

Stimulated by a recent article in the *Journal of the Kansas Medical Society*, I should like to bring the context of that message to the attention of the physicians of the State of Connecticut.

The article in question deals with the problems of adoption and the relation of the child placement agency and the private physician to the matter and to each other in the handling of the sometimes extremely intricate and delicate situations which may be involved.

As physicians and parents, we are anxious for the best welfare of our own children and yet sometimes fail to adequately assess the needs of adoptive children and their future parents. It is in the careful, patient, and thorough investigation that child placement agencies can carry out, that they, together with the physician, can best assure an environment that most nearly approaches the perfect, for the adoptive child and parents. The physician who places the adoptive child within his own community and frequently within close geographical proximity to the natural parents runs great risk of future psychologic upheavals involving natural, adoptive parents and child. The agency, on the other hand, by assuming interim custody of the child can place the child more advantageously and assure greater secrecy in the personalities involved. To quote directly: "No mother can sign her child over to

adoptive parents legally without their names appearing on the release, and unless procedure is pursued illegally, she then knows where her baby is going. In agency transactions, the baby is assigned to the agency, keeping the personalities completely apart. The agency's investigation insures that both natural parents give complete and legal permission for the adoption and, further, that both adoptive parents are wholeheartedly in accord with the plan and are not likely to change their minds."

That agency investigations take time and involve some red tape, I cannot deny, yet as an obstetrician and gynecologist the nine months duration of normal pregnancy is constantly brought to my attention. The time spent in the detailed interviews does serve the useful purpose of assuring future happiness within, of course, the limits of human error. The adoptive home must be studied thoroughly and adequate background knowledge of the natural parents is essential.

Physicians in general and obstetricians in particular are frequently requested by childless friends to aid in the obtaining of an adoptive child. So long as the great disparity between supply and demand exists, this situation will endure. It is a natural tendency to want to help such people; in his zeal to assure happiness to the childless couple, the physician may neglect to adequately assess the situation in all its ramifications, a fact which may later lead to great emotional trauma for child and parents. It is here that the trained social worker can be of inestimable aid to the physician. Unhappy indeed is the physician, who with all best intentions to create happiness and with no personal financial gain in mind, suddenly finds himself involved in charges of "black market baby traffic."

This is not a problem to be handled solely by agencies or physicians but by both working in concert. Unfortunately many physicians have a fear of agencies born largely of ignorance of their methods and intentions. It is the aim of this communication to foster better knowledge and understanding between the physician and the child placement agency and to urge the physician to utilize the facilities made available to him for the assurance of a better adoptive family. The physician can best serve the adoptive child and parent by taking an active part in the adoption agency and giving freely of his advice and medical judgment; the agency should welcome his interest.

Sincerely yours,

Alexander Bellwin, M.D.

EIGHTH ANNUAL CONNECTICUT CANCER CONFERENCE FOR PHYSICIANS

Wednesday, March 23 — 12:45 to 5:45 P. M.

Hotel Taft, New Haven

PROGRAM

12:45-1:00 REGISTRATION

*Presiding, BLISS B. CLARK, M.D., Chief of Staff and Chief Surgeon,
New Britain General Hospital*

1:00 INTRODUCTORY REMARKS

Ashley W. Oughterson, M.D., President American Cancer Society, Connecticut Division

1:05 CANCER OF THE COLON—A Symposium Covering Diagnosis, Surgery, Polyps, True Survival Rates and Ulcerative Colitis

Richard B. Cattell, M.D., moderator; Director, Lahey Clinic; Surgeon in Chief, New England Baptist Hospital, Boston

Michael R. Deddish, M.D., Assistant Clinical Professor of Surgery, Cornell University Medical School; Associate Attending Surgeon, Memorial Hospital, New York City

Edward J. Ottenheimer, M.D., Associate Clinical Professor of Surgery, Yale University School of Medicine; Surgeon in Chief, Windham Community Memorial Hospital, Willimantic

Clarence Dennis, M.D., Professor of Surgery and Chairman of the Department of Surgery, State University of New York College of Medicine, New York City

2:30-3:00 INTERMISSION

3:00 CANCER OF THE BREAST—A Symposium Covering Surgery, Irradiation and Hormonal Therapy

Cushman D. Haagensen, moderator; Associate Professor of Clinical Surgery, Columbia University College of Physicians and Surgeons; Associate Attending Surgeon, Presbyterian Hospital, New York City

Maurice Lenz, M.D., Professor of Clinical Radiology, Columbia University College of Physicians and Surgeons; Consultant Radiotherapist, Francis Delafield Hospital, New York City

Grantley W. Taylor, M.D., Assistant Clinical Professor of Surgery, Harvard Medical School; Visiting Surgeon, Massachusetts General Hospital, Boston

Norman Treves, M.D., Associate Professor of Surgery, Cornell University Medical School; Attending Surgeon, Memorial Hospital, New York City

4:30 SOCIAL HOUR

Sponsored by

Connecticut Division, American Cancer Society
Association of Connecticut Tumor Clinics

Connecticut State Medical Society
Connecticut State Department of Health

FOURTH ANNUAL CONNECTICUT CAMPAIGN FOR AMEF

Connecticut physicians will receive their first invitation to support the Fourth Annual Campaign for AMEF the latter part of March.

Our medical schools have been considerably helped by physicians and corporate contributors in the three previous campaigns of the American Medical Education Foundation and the National Fund for Medical Education.

Continuing help is needed, however, if the schools are to maintain high standards and meet increased educational and research obligations.

Give All You Can
As Often As You Can

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington

Chairman

Harold A. Bergendahl, Norwich

Burdette J. Buck, Hartford

James C. Canniff, Torrington

Morris A. Hankin, New Haven

Harry C. Knight, Middletown

James H. Root, Jr., Waterbury

Alfred J. Sette, Stamford

Audio-Digest Foundation to Exhibit at Annual Meeting

A special 20 foot exhibit concerning the post-graduate medical education program of the Audio-Digest Foundation will be among the educational exhibits at the Society's 163rd Annual Meeting, April 26, 27 and 28 at the Stratford High School. The various types of tape recordings produced by the Foundation for use by physicians will be demonstrated by representatives of the organization.

The Foundation is a nonprofit subsidiary of the California Medical Association. It serves physician subscribers by reviewing current medical literature in approximately 600 journals. These reviews are then recorded on plastic tapes for mailing to subscribers. The activities of the Foundation have expanded rapidly since inauguration early in 1953 and thousands of physicians have become subscribers throughout the United States and other countries. Originally started as a service for physicians in general practice, the services have now been expanded to include a number of the medical specialties.

The services have been implemented by the preparation of film strips and slides to accompany the tape recordings. A unique feature of the program is a provision in the articles of incorporation that any surplus that may be accrued by the organization is to be contributed to the medical schools through the American Medical Education Foundation.

Junior Chamber of Commerce Sponsors Community Health Week

The approximately thirty chapters of the Junior Chamber of Commerce in Connecticut will participate in a national observance of community health week, March 21-27, in cooperation with the National Health Council.

David Oscarson, New Haven, president of the

Connecticut Chapter, has announced that plans for the observance have been extensively developed by several chapters and that others are engaged in committee meetings with community leaders to plan for the event.

State and local medical associations, hospital groups and voluntary health associations are assisting the officers of local chapters in their plans. The program is aimed at enlisting the participation of 180,000 young business men in 2,800 communities and the theme of the program will be "Know Your Community Health Resources."

New Haven Emergency Service Modified

The emergency medical call service sponsored by the New Haven Medical Association has recently been modified to provide more effective service in the East Haven area.

It was announced by Dr. Samuel Spinner, chairman of the committee in charge of the service, that a panel of seven East Haven physicians will be on call for emergencies in that area. The plan has been coordinated with the police department in the same manner as in other communities and with the central emergency switch board in New Haven.

A Former Advertiser is Heard From

It is with pleasure and confidence that Professional Equipment Company of New Haven announces the election of Herbert M. Bentley as its new president. Now completely recovered from their bad fire of a few months ago, Professional looks forward from larger and better quarters than ever before to a continuation of the progress that has typified its growth in the past.

Charles F. Hewitt, retiring from the post of president which he has held for the last thirty-three years, will remain active in the company as treasurer and in an advisory capacity as chairman of the Board. In stepping out as president, Fred Hewitt said that he was particularly proud of the help of

his associates in maintaining a record, year after year, of business always better than the year before, and that 1954 was no exception, being by far the best year in the history of the company.

Mr. Bentley's unanimous election as the new president climaxes for him sixteen years of experience and promotions through all of the important departments of the business. Herb Bentley came with Professional in 1939. His interest and ability in the Service Department first won recognition with an appointment as service manager. After a couple of years he transferred to the Sales Department and made rapid strides in the surgical and x-ray field till he became a top producer. His next promotion gave him the title and responsibilities of branch manager. In 1949 he bought an interest in the firm and assumed still further management duties. He was also recently elected to the Board of Directors.

Mr. Bentley takes over the active control of the company in an atmosphere of complete belief in his ability and assurance throughout the organization of better years than ever just ahead, and better service than ever to Connecticut doctors and hospitals under his management.

Fairfield County Association Sponsors Press-Radio Conference

A press-radio conference, sponsored by the Fairfield County Medical Association, was attended by 26 editors, radio station managers and officers of the Association, Tuesday evening, February 15, at the Weeburn Country Club, Darien. Alfred J. Sette, chairman of the Association's Public Relations Committee, presided and outlined the principle problems encountered furnishing medical information for publication. The meeting was then devoted to general discussion of the means of cooperation between medical associations and communications media.

Peacetime Benefits for Future Veterans

The Veterans Administration has announced that persons entering the armed forces for the first time on and after February 1, 1955 will be peacetime veterans when they leave service and as such, will be entitled only to peacetime benefits.

County Association Annual Meetings

Fairfield County—Monday, April 4
Hartford County—Tuesday, April 5.
Middlesex County—Thursday, April 14.
New Haven County—March 24.
New London County—Thursday, April 7.
Tolland County—Tuesday, April 19.
Windham County—Thursday, April 21.

Peacetime veterans, under present laws, will not be eligible for any of the benefits provided by the Korean GI bill, nor for any wartime service benefits payable to veterans of the Korean conflict period.

Peacetime veterans may be entitled, under certain conditions, to medical and domiciliary care, disability compensation, aid for the blinded, "wheel chair" homes, servicemen's indemnity, guaranty of commercial life insurance premiums, burial expenses, burial flag, guardianship service and appeals. Their dependents may be entitled to death compensation where the veterans die of service connected causes.

Hospital Service Prepayment in Connecticut

Figures recently released by the Commission on the Financing of Hospital Care show Connecticut to be the fourth ranking state in the United States, according to the per cent of population, covered by nonprofit hospital service prepayment plans. In 1953, fifty-one per cent of the Connecticut population was covered.

How this directly affected the income budgets of Connecticut hospitals during the fiscal year ended September 30, 1954 is shown in a study just completed in the CHA office. High member hospital was Bristol, with fifty-four per cent of its patient days of service rendered to beneficiaries of Connecticut Hospital Service, Inc., subscribers. Sharon Hospital, however, at the other end of the scale, developed only nine per cent of its days as CHS days. St. Vincent's Hospital, Bridgeport, with thirty-seven per cent, came closest to the average for the State.

FROM OUR EXCHANGES

Science (120:3126, Nov. 26, 1954) informs us that H. Runge (Germany), using primarily radium and x-ray in the treatment of carcinoma of the cervix, reported an absolute recovery rate of 45 per cent after 5 years and 40 per cent after 10 years. In Russia, complete clinical recovery was obtained in the treatment of cancer of the cervix with radiotherapy in 75.1 per cent of stage 1 cases, 51.3 per cent of stage 2, and 12.5 per cent of stage 3, as reported by E. A. Bazlov. After radical mastectomy for the treatment of breast cancer, E. Viacava (Argentina) gave the following figures for those living after 5 years: 69 per cent of stage 1 cases; 29 per cent of stage 2, 9 per cent of stage 3, and none of stage 4. Stages 3 and 4 patients received radiation and hormone therapy.

* * * *

Those physicians who have developed the habit of eagerly watching for Dr. William B. Bean's occasional contributions to medical thought will not be disappointed in his recent article entitled "Delirium Cordis" (*Dis. of Chest*, XXVI:4, pp. 381-393).

Dr. Bean states that the firmest plank "in my platform of conviction and behavior is that physicians as members of an ancient profession owe society, or as I prefer to say, our fellow man, a debt of thoughtful criticism. If criticism is to have value it demands the use of the intellect." His formidable title of "Delirium Cordis" poses a question as well as a puzzle to the thoughtful. There is a partially hidden satiric truth in the lines of two delightfully amusing verses.

On Dr. Bean's sayso we can accept his theme as "a series of non sequiters presented in a perfectly logical manner." The cardiovascular system, heart disease, the "radical and revolutionary development of cardiac surgery" which allows the surgeon to invade the once inviolate sanctuary of the body, namely, the heart, overspecialization and the perplexing multiplication of voluntary health organizations are all touched upon in some detail.

Finally, Dr. Bean dwells at some length on the thought that "weakness or uncertainty or stupidity

does not get a second try in nature. Even a cheerful and optimistic person should ponder the question of whether a man can escape the responsibility for thinking or abuse the results of thinking and the less objective but no less real aspirations and yearnings of his spirit. For in recorded evolution the price of failure is extinction."

The final lines of Dr. Bean's introductory verse perhaps fully detail his thinking.

"Such introductory masterpieces
Are only smoke screens for my thesis
Which is that we must all be led
By heart as well as brilliant head."

* * * *

Haiht *et al.* tested the efficacy of erythromycin in the treatment of acute respiratory disease in 269 Navy recruits (*U. S. Armed Force Med. Jour.* V:10, pp. 1405-1421). The observation seems to have been controlled. Comparison was made between erythromycin, penicillin and a placebo. Erythromycin and penicillin had a beneficial effect in streptococcal infections. Nonbacterial respiratory infections were not benefited by the administration of either of the antibiotics. The authors conclude that the administration of either of the antibiotics, when compared with the course in the placebo group, did not alter the course of the infection. No complications occurred in their series of cases. The routine use of erythromycin or penicillin in the treatment of viral or related nonbacterial respiratory infections is of little or no value in affecting the acute infections, and for economic and medical reasons should be avoided.

* * * *

Electroencephalographic abnormalities in endocrine disease have been shown by Condon *et al.* to be significantly increased in patients with supposedly purely endocrine disorders (*New Eng. Jour. Med.*, 251:16, pp. 638-641). The authors pose the question of whether or not some symptoms in these cases are primarily or secondarily neuronal, rather than purely endocrine.

* * * *

According to Wright and McDevitt cerebral vascular diseases are among the most serious and common of all (*Ann. Int. Med.*, 41:4, pp. 682-697). The present state of our knowledge of these diseases and of the results of treatment are far from satisfactory. The differential diagnosis is not of purely academic interest. There are various aids in diagnosis that are discussed. Vasospasm occurs in the cerebral arteries and is of importance in terms of a warning. Cerebral hemorrhage is always serious. Subdural and extradural hemorrhage may call for surgical interference. Most other cerebral hemorrhages are not amenable to specific therapy. Sympathetic block for acute thromboses and emboli are under investigation. The use of anticoagulant drugs in the treatment of thrombosis and embolism is being investigated. Their trial use appears to be justified by the results, but their final evaluation awaits the future. A considerable part of the discussion is given over to an analysis of the results of using anticoagulant drugs. There appears to have been some reduction in the incidence of recurrent thromboses in the arteries of the brain and the emboli arising from thrombi in the heart of patients suffering from rheumatic heart disease or from acute myocardial infarction. There is some risk from hemorrhage in the treatment of these diseases with anticoagulants but the risk is not excessive.

* * * *

Kahn rather briefly summarizes "Twenty Years' Experience with the Surgery of Hypertension." (*New Eng. Jour. Med.*, 251:16, pp. 633-637.)

In Dr. Kahn's opinion sympathectomy, followed by a medical regimen such as a salt-free diet, if necessary, is at present the most successful treatment for severe or progressive hypertension of unknown origin. The operation should not be performed if there is evidence of renal failure as shown by an accurate determination of non protein nitrogen of the blood or blood urea nitrogen.

The standard procedures of today all have merit. The surgeon should follow the one in which he has had training, or the one which best suits the individual needs of the patient.

Dr. Kahn regrets that a procedure that has been proved by highly competent surgeons to improve life expectancy in severely ill, hypertensive patients has not been accepted by the majority of practicing physicians.

* * * *

The diagnosis and treatment of Meniere's disease has probably bothered every general practitioner at some point in his career. Walsh thinks that the term should be confined to those cases exhibiting the classical triad of tinnitus, vertigo and nerve deafness, the result of endolymphatic hydrops (*Jour. S. Car. Med. Assoc.*, L:10, pp. 296-299). Functional tests of hearing are important and should exhibit (1) nerve loss, usually flat throughout the scale of pure tone audiometry, (2) recruitment or hyper-recruitment, (3) diplacusis, and (4) a comparatively great discrimination loss for the threshold loss of hearing for speech. Caloric tests may not be informative, though long standing cases usually show an hypactive labyrinth on the affected side.

Medical therapy with vasodilator, with histamine, or with B₁₂ may give some relief to the patient. The results of therapy should be judged in the light of known periods of remissions.

The surgical ablation of the labyrinth will give complete relief in cases of unilateral hydrops, provided a complete destruction of the vestibular labyrinth is accomplished. It is important that the utricle and saccule as well as the semicircular canals be destroyed.

* * * *

The office treatment of ambulatory schizophrenics, according to Jackson, offers some very real advantages (*Cal. Med.*, 81:4, pp. 263-267).

Among the suggested advantages are (1) lesser pecuniary costs to the patient and family, (2) the maintenance of the patient's self esteem by his continued life in the community, especially if he is kept at some sort of gainful occupation and (3) avoidance of the schizophrenics' tendency to increase their loss of contact with reality if, as in a hospital, they are taken care of and not expected to assume any responsibility for themselves.

The office treatment of a schizophrenic does entail special problems of therapy and of dealing with the relatives and the community. However, it is felt that attention to these problems results in the successful social restoration of patients who formerly would have been thought too ill to remain outside a hospital setting.

The author concludes that while this is among the most demanding work that a psychiatrist can engage in, the rewards are great.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Newell W. Giles, Darien

President-Elect, Mrs. Norman J. Barker, Collinsville

First Vice-President, Mrs. J. ALFRED WILSON, Meriden

Second Vice-President, Mrs. Frank L. Polito, Torrington

Recording Secretary, Mrs. Charles Culotta, Hamden

Corresponding Secretary, Mrs. C. Murray Gratz, Cos Cob

Treasurer, Mrs. Joseph Woodward, New London

The Colorado Woman's Auxiliary was so well impressed with the "First Aid Chart" worked out by the Connecticut State Medical Society and the Auxiliary's Public Relations and Rural Health Committee that it asked permission to copy and distribute it at the AMA sponsored exhibit at Denver's Great Western Stock Show. In the words of Colorado Auxiliary's president, Mrs. John B. Grow, "our Board and Health Education Committee feel that 'The First Aid Sheet' fits in very well with the AMA 'Farm Accident Exhibit.' Since the stock show draws many rural people from our own and several neighboring states, we feel the exhibit is a good public relations gesture"

Civilian Defense

The series of First Aid demonstrations seen over WNHC-TV on Tuesdays from 3:00-3:30 P. M. is the first of its kind in the country. It is presented by the Connecticut State office of Civil Defense and WNHC-TV in cooperation with the American Red Cross. Actual demonstrations of First Aid techniques are given by Red Cross instructors. The program will run through April 12.

The Connecticut State Department of Education has been awarded a grant of \$15,000 by the Federal government to develop curriculum projects on instructional materials to prepare children and adults to meet emergencies arising from war or natural disasters. The project will cover such topics as safety, health, food preparation, evacuation procedures and various sciences.

School Health

A letter has been sent to all county School Health chairmen requesting them to find out whether the area PTA's have a health and accident chairman and suggesting that, if they have not, they appoint a physician's wife to the position. Mrs. Creighton Barker or Mrs. Dewey Katz has attended all meet-

ings of the Connecticut Advisory School Health Council. Special stress has been placed on a good over-all dental program in the schools.

Connecticut Health League

The annual meeting of the Connecticut Health League was held in January. Mrs. Dewey Katz has distilled the salient facts from the panel discussions, as follows:

1. Most alcoholics are neurotics or mentally pathological in some sense. Therefore, they are in need of psychological treatment as well as other forms of medical treatment.

2. That there is need to educate the public that many mental diseases are subject, today, to short-term treatment and patients need not necessarily be admitted to mental hospitals for adequate treatment. Many general hospitals today have psychological divisions that can treat such individuals.

- a. There is a definite need for more psychological divisions, or departments, connected with general hospitals.

- b. A shortage of trained personnel, especially in the field of rehabilitating the patient for useful life in his community.

5. That the cost of care for patients in Convalescent, Nursing and Boarding Homes has increased and that if we expect such patients or persons to get adequate care, we, the public, must be willing to pay for it.

The program contained no speeches. There was a moderator, Edwin R. Meiss, executive director, American Cancer Society, Connecticut Division, Inc. There was a Question Panel, with Jessie P. Halbert, executive director of the Meriden Public Health and VNA representing the public health nurse; Mrs. Deenah Stolman, director of social service for Hartford Hospital, representing the medical social worker; Mrs. Violet Harris, supervisor of welfare, Town of Hamden, representing the family

case worker. On the answer panel were Richard O. West, administrator of Norwalk Hospital, representing the general hospital; Dr. John J. Blasko, Commission of Mental Health, representing the special hospital; Dr. Sidney Shindell, director, representing the Committee on Care of the Chronically Ill; Joseph W. Reath, executive secretary of the Connecticut Private Hospital Association, representing the convalescent and nursing home; Dr. Margaret duBois, chief of the Division of Hospitals, Connecticut State Department of Health, representing the boarding home and home for the aged.

County News

FAIRFIELD

Fairfield is planning a bridge and fashion show at the Ritz in Bridgeport for this month.

HARTFORD

Hartford had to turn away the crowds at its County Medi-Capers held the night of February 5 at New Wampanoag Country Club. Mrs. A. S. Deming and Mrs. John Allen were co-chairmen. The primary purpose of the evening was fun but the combined talents of doctors and wives, plus the Hartford Hospital Glee Club, was so attractive that the event cleared \$600. In the words of the president, Mrs. Robert Tennant, "the talent was amazing and everyone had a wonderful time." Monies from this and a January dessert card party, which added over \$500 to the treasury—Mrs. Asa J. Dion and Mrs. Curtiss B. Hickox were the chairmen—were used for the scholarship fund and the AMEF.

LITCHFIELD

Litchfield reports the organization of a Future Nurses' Club in Winsted.

The Revisions Committee is working on the revision of the county constitution using as a guide the constitutions of Hartford, New London, and Middlesex counties as well as the model county constitution furnished by National.

MIDDLESEX

Middlesex is well over 100 per cent subscribed to *Today's Health*. Its quota is 57 and it already has 78 points.

Contributions from members amounting to \$90.25 have been received for the AMEF.

Mrs. Charles Russman, past president of the county, has been appointed Mental Health chairman of the District Nurse Association, Middletown.

Mrs. C. B. Crampton is serving on the Board of Directors of the Greater Middletown Community Chest.

NEW LONDON AND WINDHAM

New London and Windham co-sponsored a dinner dance in February for the benefit of the AMEF.

Macy Foundation Supports Pregnancy Research

An expanded program for the support of research and conferences on the physiology of pregnancy was announced by Willard C. Rappleye, president of the Josiah Macy, Jr. Foundation, at the 25th annual meeting of the directors. In the past the foundation has given emphasis to the support of scientific investigations on the problems of psychosomatic medicine and of aging, but with enlarged resources now available, the directors have decided to give special attention to the prenatal phases of human development and the maternal adaptation to pregnancy. They will assist departments of obstetrics and gynecology to develop programs of clinical and basic research.

THE DOCTOR'S OFFICE

Arthur J. Driscoll, M.D. announces the opening of an office for the practice of orthopedic surgery at 123 Maple Street, Bristol.

Fred Gibson, M.D. announces the removal of his office for the practice of obstetrics and gynecology to 37 Trumbull Street, New Haven.

Joseph L. Horowitz, M.D. announces the opening of an office for the practice of obstetrics and gynecology at 2839 Main Street, Bridgeport.

Thomas G. Kantor, M.D. announces the opening of an office for the general practice of medicine at 29 Elm Street, Westport.

A. E. Hertzler Knox, M.D. announces the opening of an office for the practice of internal medicine at 1139 Farmington Avenue, West Hartford.

Alan R. Small, M.D. announces the opening of an office for the practice of internal medicine in the Professional Building, Lafayette Street, Bridgeport.

SPECIAL NOTICES

CONNECTICUT VETERANS ADMINISTRATION MEDICAL SOCIETY

- March 3
Atopic Allergies
A. Arthur Fierberg, M.D.
- March 10
Functions of VR&E Divisions in a Regional Office
Setting
Thomas J. Skelley, Jr., chief, Counseling Section,
VR&E Division
- March 17
Clinicopathological Conference
Moderator: Paul M. Sherwood, M.D.
- March 24
Review of Tuberculosis Outpatient Program
Einar A. Lundberg, M.D.
- March 31
Case Presentation: Surgical Treatment of Mitral Stenosis
Paul M. Sherwood, M.D.
- Meetings are held at 8:30 A. M. at the Veterans Administration Regional Office, 95 Pearl Street, Hartford, Connecticut, in the Main Conference Room. All interested physicians are cordially invited to attend.

HARTFORD MEDICAL SOCIETY

Guest Speakers March and April, 1955

- 5:00 and 8:30 P. M., Hunt Memorial Building, 38 Prospect Street, Hartford, Connecticut.
- March 7
Samuel P. Harbison, M.D., University of Pittsburgh, Pittsburgh, Pennsylvania
Routine Orders and Humbug
- March 21
Thomas A. Warthin, M.D., Veterans Administration Hospital, West Roxbury, Massachusetts
Gastrointestinal Bleeding
- April 4
Conrad M. Riley, M.D., Presbyterian Hospital, New York, New York
Bright's Disease in Children
- April 18
Louis A. Soloff, M.D., Temple University Hospital
Medical Aspects of Mitral Commissurotomy

SENATOR PURTELL'S RADIO AND TV SCHEDULE

STATION WNHC-TV (New Haven)

March 18, 1955	7:00 P. M.
April 15, 1955	7:00 P. M.
May 20, 1955	7:00 P. M.
June 17, 1955	7:00 P. M.
July 15, 1955	7:00 P. M.

The bi-weekly radio broadcasts originate with Station WTIC (Hartford) and then are rebroadcast by stations WELI (New Haven) and WICC (Bridgeport):

WTIC (7:15 P.M.)	WELI (7:15 P.M.)	WICC (7:00 P.M.)
March 11	March 12	March 13
March 25	March 26	March 27
April 8	April 9	April 10
April 22	April 23	April 24
May 13	May 14	May 15
May 27	May 28	May 29
June 10	June 11	June 12
June 24	June 25	June 26

In these broadcasts Senator Purtell attempts to discuss news and issues emanating out of Washington which he believes will be of interest to you. He will be most pleased to have any comments which you would like to send in regard to these programs and any suggestions concerning them as to subject matter to be covered et cetera will be welcome. Your comments will greatly assist him in planning the programs so that they may be of the most possible interest to you.

POSTGRADUATE COURSE ON PULMONARY FUNCTION

The American Trudeau Society, medical section of the National Tuberculosis Association, announces a repetition of the Postgraduate Course on "The Measurement of Pulmonary Function in Health and Disease," to be sponsored by the medical schools of Harvard University, Tufts College, and Boston University, March 21-25, 1955. This course is aimed at physicians interested in diseases of the chest who wish to acquaint themselves with the methods used in the evaluation of pulmonary function. Methods of analysis of pulmonary function and related cardiac function will be described and demonstrated. Tuition is \$50. Applications and more detailed information may be obtained from Dr. Edward J. Welch, 1101 Beacon Street, Brookline 46, Massachusetts.

The Connecticut Tuberculosis Association and its medical section, the Connecticut Trudeau Society, will make available a limited number of scholarships for this course. Information concerning scholarships may be obtained from Miss Mabel Baird, executive director, Connecticut Tuberculosis Association, 17 Woodland Street, Hartford.

INTERNATIONAL ACADEMY OF PROCTOLOGY

The 7th annual convention of the International Academy of Proctology will take place at the Plaza Hotel in New York, 23-26 March, 1955. The international, national, and local program committees are planning an unusual seminar on anorectal and colon surgery. There will be special emphasis on anorectal presentations and on panel discussions, as requested by those who attended the Chicago meeting in 1954. Plans are being developed for wet clinics and lectures at the Jersey City Medical Center under the direction of Earl Halligan, surgeon-in-chief of the Medical Center.

Speakers from this country and from abroad will present papers and motion-picture demonstrations of their personal techniques. Mexico is expected to be very well represented at this meeting. All physicians and their wives are cordially invited to attend the convention, whether or not they are affiliated with the academy. There is no fee for attendance.

AMERICAN ACADEMY OF GENERAL PRACTICE

The Seventh Annual Scientific Assembly of the American Academy of General Practice will be held in Los Angeles, March 28-31, 1955.

Officers and Delegates will register at Hotel Statler, 10:00 A. M. to 2:00 P. M. Saturday, March 26. General registration opens at Shrine Auditorium at 10:00 A. M. on Sunday; 8:30 A. M. Monday through Thursday. No registration fee for Academy members; non-member registration, \$5. Registration fee for residents, interns and medical students who present credentials will be paid by the Academy. All AMA members are invited to attend the scientific sessions.

The regular annual meeting of the Congress of Delegates will convene Saturday, March 26, at 2:00 P. M. in Hotel Statler. Reference committees will meet that evening and the following morning. Other sessions of the Congress are scheduled for 2:00 P. M. Sunday and 9:00 A. M. Monday. All state chapter officers are invited to a dinner in their honor, 6:00 P. M. Sunday, at Hotel Statler. The Board of Directors will meet at 10:00 A. M. Friday, March 25, and 1:00 P. M. Thursday, March 31.

CARDIAC GRAND ROUNDS

Thursday, April 7, 1955, 11:00 A. M.
Nurses' Auditorium, St. Mary's Hospital

Formal Papers—11:00 A. M. to 1:00 P. M.

1. Heart Disease of Unknown Etiology—by Dr. Charles A. R. Connor, assistant professor of clinical medicine, New York University Post-Graduate Medical School.

2. Myocarditis—by Dr. Charles E. Kossmann, associate professor of medicine, New York University College of Medicine.

3. Prophylaxis of Rheumatic Fever—by Dr. Gene H. Stollerman, instructor in medicine, New York University College of Medicine, and medical director of Irvington House.

2:30 P. M. Clinical case conference—Drs. Connor, Kossmann and Stollerman.

SYMPOSIUM ON TREATMENT OF CARDIOVASCULAR DISEASE

Sponsored by the Stamford Heart Association

Presiding: Dr. William H. Resnik, associate clinical professor, Yale University School of Medicine.

April 19, 1955

MORNING SESSION

9:30-10:00

Registration (No fee)

10:00-10:15

Dr. John W. Haine, President, Stamford Heart Association

Greetings

Dr. William H. Resnik

Introductory Remarks

10:15-10:45

Dr. Janet S. Baldwin, associate professor of pediatrics, NYU-Bellevue Medical Center

Diagnosis and Medical Management of Congenital Heart Disease

10:45-11:15

Dr. Robert E. Gross, Ladd professor of children's surgery, Harvard Medical School

Surgery in the Treatment of Congenital Heart Disease

11:15-11:45

Dr. William W. L. Glenn, chief of cardiovascular section, Yale University School of Medicine

Surgery in the Treatment of Acquired Heart Disease

11:45-11:50

Intermission

11:50-12:30

Panel Question Period

AFTERNOON SESSION

2:00-2:30

Dr. John P. Merrill, associate in medicine, Harvard Medical School

Diuretic Agents and their Mechanisms

2:30-3:00

Dr. Arthur C. DeGraff, professor of therapeutics, NYU-Bellevue Medical Center

Use of Digitalis and the Cardiac Glycosides

3:00-3:30

Dr. Perrin H. Long, director of medical service, State University of New York College of Medicine at New York City

Treatment of Bacterial Endocarditis

3:30-3:45

Intermission

3:45-4:15

Dr. Arthur M. Fishberg, director of medicine, Beth Israel Hospital, New York City
Management of Hypertension

4:15-4:45

Dr. Samuel A. Levine, clinical professor of medicine, Harvard Medical School

Pitfalls in the Treatment of Cardiovascular Disease

4:45-5:30

Panel Question Period

THE AMERICAN GOITER ASSOCIATION

The 1955 meeting of the American Goiter Association will be held in the Skirvin Hotel, Oklahoma City, Oklahoma, April 28, 29 and 30, 1955.

The program for the three day meeting will consist of papers and discussions dealing with the physiology and diseases of the thyroid gland.

COURSE IN THE CLINICAL PATHOLOGY AND PATHOLOGY OF PARASITIC DISEASES

A short intensive course on the laboratory diagnosis and pathology of parasitic infections will be presented August 15-27, 1955 at the Louisiana State University School of Medicine in New Orleans.

The course is designed primarily for pathologists and technologists. However, general practitioners, internists, pediatricians, gastroenterologists and physicians engaged in the practice of public health and tropical medicine who are interested in the laboratory diagnosis of parasitic infections are welcome to attend. The instruction and training will be of assistance to pathologists who are preparing for board examinations, to pathologists and physicians who are responsible for the diagnosis of parasitic infections in their laboratories, and to technologists engaged in this specialty.

The course will include lectures, extensive demonstrations, films and supervised individual laboratory study. Emphasis will be placed upon the practical aspects of laboratory diagnosis of common parasitic infections, including training in stool examination and stool concentration technics. Abundant material from patients with parasitic diseases endemic in this area will be available for examination. Comprehensive slide sets containing parasitic organisms in tissue sections will be studied. Library facilities are available. The medical school building is air conditioned.

Registrants should bring their microscopes, equipped with mechanical stages, and their microscope lamps. A limited number of places will be available. The fee for the course is \$50.

Persons interested in attending this course may write to: Dr. Clyde Swartzwelder, Department of Microbiology, Louisiana State University School of Medicine, 1542 Tulane Avenue, New Orleans 12, Louisiana.

OTOLARYNGOLOGY ASSEMBLY

The Department of Otolaryngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology from September 19 through October 1, 1955. This Assembly will consist of two parts.

Part I. September 19 through September 24, 1955, will be devoted to surgical anatomy of the head and neck, fundamental principles of neck surgery and histopathology of the ear, nose and throat. This week will be under the personal direction of Maurice F. Snitman, M.D.

Part II. September 26 through October 1, 1955, will be devoted entirely to lectures and panel discussion of advancements in otolaryngology. The chairman of this section will be Emanuel M. Skolnik, M.D.

Registration is optional for one or both weeks.

INTERNATIONAL FERTILITY ASSOCIATION CONGRESS

The International Fertility Association (I.F.A.) announces its Second World Congress which will be held in Naples on May 1956.

The I.F.A. founded in Rio de Janeiro in 1951, sponsors once every three years a World Congress with the aim of joining the scholars (medical men, veterinarians and sociologists) interested in the problems of fertility and in the fight against sterility.

The First World Congress of the I.F.A. held in New York in May 1953, was crowned by the greatest success for the importance of scientific contributions by the leading men in the field of sterility problems.

The major topics of the Congress are the following:

I—Endocrine and metabolic factors in Fertility and Sterility.

II—Professional (occupational) and toxic factors in relation with Fertility.

III—New methods of diagnostic and treatment of male Sterility.

IV—New methods of diagnostic and treatment of female Sterility.

V—Diagnosis of ovulation and its disorders.

VI—Diagnosis of spermatogenesis and its disorders.

VII—Treatment of disorders of ovulation.

VIII—Treatment of disorders of spermatogenesis.

IX—Surgery of male Sterility.

X—Surgery of female Sterility.

XI—Experimental investigations in Fertility and Sterility.

XII—Problems in animal reproduction (Veterinary).

More detailed information about the Congress and the final program will be sent after reception of the Registration, Professor G. Tesaro, chairman of the Committee on Arrangements, Via S. Andrea Delk Dame, 19, Napoli, Italy.

Health and Welfare Bills in Connecticut General Assembly House

HB9—The Administration of Medications and Sedatives to Patients in Private Hospitals provides to prohibit the administration of medications and sedatives to patients in private general, private mental and private chronic or convalescent hospitals and private homes for the aged except on the advice of a physician by requiring weekly examinations of patients.

HB22—An Increase in the Penalties for Persons Operating a Motor Vehicle While Under the Influence of Intoxicating Liquor or of Any Drug provides increase of penalties for persons operating a motor vehicle while under the influence of intoxicating liquor or of any drug.

HB27—Support in State Humane Institutions. Identical with SB26.

HB28—Exemption From the Sales and Use Tax of Wheel Chairs, Hearing Aids, Artificial Limbs, Braces, etc. provides for exemption of handicapped persons from payment of the sales tax.

HB51—Support of Inmates at Mansfield and Southbury Training Schools provides elimination of charges for education and training included in the per capita cost for inmates in the two state training schools in order to correspond such education and training to that available in the free public schools of the state.

HB61—Exemption From the Sales and Use Tax of Wheel Chairs, Hearing Aids, Artificial Limbs, Braces, etc. Identical with HB28. From Legislative Council.

HB64—The Abandonment of Refrigerators, Ice Boxes and Other Containers provides a penalty for the abandonment of air-tight refrigerators, ice boxes and other containers which are hazardous to children. From Legislative Council.

HB113—Providing for a Medical-Dental School at the University of Connecticut. Identical with SB47.

HB117—To Establish an Experimental School Social Work Program in Four Towns or Groups of Towns Where Such Service Does Not Exist provides to assist teachers in identifying children with emotional problems at a time when early treatment will be most effective and to provide a demonstration of the effectiveness of school social worker services in order to encourage smaller communities to establish them on a permanent basis.

HB142—Providing for Hearings Before Commitment to State Mental Hospitals provides to prohibit the commitment of any person to a mental hospital without a hearing.

HB147—Tests for Intoxication of Motor Vehicle Operators provides for establishment of tests and standards for determining intoxication of drivers.

HB175—Creating an Appeal for Patients in Tuberculosis Sanatoria provides for establishment of a board to

which appeals may be taken concerning charges for support in the state tuberculosis sanatoria.

HB176—Making an Appropriation to the Department of Mental Health for the Connecticut Child Study and Treatment Home provides to enable the Department of Mental Health and the Board of Trustees to carry out the intent of the general assembly in creating The Connecticut Child Study and Treatment Home, and to carry out the purposes of the acts by which they were created, by providing residential treatment facilities for these children through site preparation, erecting and equipping buildings.

HB177—The Admission of Physically Handicapped Children to the Newington Home and Hospital for Crippled Children and Reimbursement for Part of the Cost of Support of Said Child While at Said Home and Hospital this act would replace the present system of case by case notification to the Welfare Commissioner and the payment of three dollars per day per case with a system by which the Newington Home and Hospital for Crippled Children would receive in monthly installments a total during each fiscal year of twenty-five per cent of their operating cost for the preceding fiscal year as established by the Hospital Cost Commission. This act would also remove the requirement of payment by the town to the Newington Home and Hospital for Crippled Children.

HB179—Assistance to Senior Citizens provides old age assistance payments to all residents of this state over sixty-five, and to eliminate the stigma of pauperism and to put added funds in circulation. Many people now deserving this aid are being deprived of it because of red tape and investigations of their past history.

HB181—Establishing a Commission on Homes for Senior Citizens provides homes for Senior Citizens.

HB182—State Sanatorium Care for Persons Afflicted With Tuberculosis provides that the state assume the cost of sanatorium care for those afflicted with active tuberculosis.

HB216—Authority of the State Board of Healing Arts to Make Rules and Regulations provides to restore to the State Board of Healing Arts authority to make rules and regulations. Such authority was provided in the law which established the Board (P.A. 1925, Ch. 161, Sec. 6) but, later, it was inadvertently omitted from a revision of the statutes.

HB219—Requirements for Certificate of Registration to Practice Medicine and Surgery provides: (1) to permit admission to examinations leading to licensure candidates, graduates of medical schools outside of the United States, who do not customarily receive the degree of doctor of medicine, but who are granted the degrees of "arts" or "physician" that are equivalent to the doctor of medicine degree in the countries of origin. (2) to permit the medical examining boards, in their discretion, to admit to examination leading to license to practice medicine in the State of Connecticut, graduates of unapproved medical schools outside of the United States who have had supplementary education in the medical schools or hospitals in the United

States. (3) to extend the privilege of accepting licenses granted by boards of medical examiners in the territories of the United States in lieu of examination. Introduced by Connecticut Medical Examining Board and approved by Council of the State Medical Society.

HB233—Providing for Expansion of Psychiatric Clinics for Children provides to increase and maintain psychiatric services throughout the state by authorizing the state department of health to make grants for local psychiatric clinics.

HB256—Exempting Sales of Medicine From the Sales Tax provides to exempt the sale of all medicines, whether by prescription or otherwise, from the sales tax.

HB259—Merger of Grace-New Haven Community Hospital and the Connecticut Training School for Nurses provides to authorize the merger of Grace-New Haven Community Hospital and the Connecticut Training School for Nurses.

HB273—Anatomy requires that bodies for anatomical purposes be preserved for forty-eight hours by institution receiving body rather than institution delivering same and eliminate obsolete bond requirement.

HB279—Authority of the State Board of Healing Arts to Make Rules and Regulations. Identical with HB216.

HB285—Unemployment Rights of Pregnant Women allows unemployment compensation to pregnant women dismissed or suspended while still able and willing to work.

HB291—Registration of Nurses provides: (1) to make the board of examiners for nursing self-sustaining by increasing registration fees. (2) to waive the citizenship requirement for nurses registered by examination for four years. (3) to permit appeal to the courts from decisions of the board of examiners for nursing.

HB300—Commitments to the Mansfield State Training School and Hospital changes the requirement for commitment from feeble-minded or epileptic to mentally deficient or epileptic and to eliminate the requirement of appointing the selectman to investigate financial responsibility.

HB301—Care of Crippled Children provides to obtain financial assistance for the Children's Center in Hamden, for care and treatment of crippled children.

HB302—Commitments to the Southbury Training School. Identical with HB300 but refers to Southbury Training School.

HB303—Mentally Deficient Persons provides uniform terminology in the statutes pertaining to mental deficiency.

HB343—Guardianship of Neglected and Uncared-For Children purpose of this act is to bring under the guardianship of the same unit of government, that is the State, all neglected and uncared-for children, whether under six or over six years of age, whether in foster homes or in county temporary homes.

HB346—Chemical Tests for the Purpose of Determining the Alcoholic Content of Blood of Persons in Connection With the Operation of Motor Vehicles or

Motor Cycles provides chemical tests for the purpose of determining the alcoholic content of blood of persons in connection with the operation of motor vehicles or motor cycles.

HB375—Preparation of Budget Requests for the Department of Mental Health provides to define the responsibility of the superintendents of state mental hospitals regarding budgets of the department of mental health.

HB376—Care and Treatment of Spastic and Mentally Deficient Infants provides for care of spastic or mentally deficient infants by the state training schools.

HB377—Preparation of Budget Requests for the State Mental Hospitals and the Child Study and Treatment Home provides to define the responsibility of the commissioner of mental health regarding budgets of the department of mental health.

HB412—Scholarship for Students of Medicine or Dentistry provides to aid Connecticut students in the study of medicine and dentistry and to encourage them to practice in the state.

HB447—Reports of the Results of Soliciting for Philanthropic Purposes provides to make it possible for the public to know who benefits from charity drives by requiring reports of receipts and disbursements of the proceeds of solicitations.

HB480—Defining the Legal Status of Findings of the Toxicological Laboratory provides to give legal status to certified reports of the toxicological laboratory in the state department of health, thus reducing court attendance for a person needed for laboratory work for coroners, medical examiners, and police and prosecuting agencies.

HB483—District Departments of Health provides clarification of tenure, compensation and duties of district boards of health and term of office for board of health members; to provide for state financial assistance on a per capita basis; to provide for withdrawal of towns from the district and to provide civil service and retirement benefits for employees.

HB510—Connecticut Public Health Code provides a more accurate title for this code in the light of modern public health regulations which cover all phases of public health.

HB511—Certificates for Licensed Practical Nurses provides for the granting of licensed practical nurses, certificates without examination to qualified persons who have had five years' experience in the care of the sick.

HB535—Support in Humane Institutions provides, in conjunction with proposed amendments to Sections 8586, 1111c, 1112c, 1147c, 1173c, and 1176c, is designed to fix the number of degree of relationship of persons legally liable for the support of persons in humane institutions, to set a maximum charge for persons in the Mansfield and Southbury State Training Schools and to provide that the charges for persons in the Mansfield and Southbury Institutions shall as closely approximate the cost of such person's home care as possible, to provide a method of review for charges inequitably set, to eliminate retroactive charges, and to provide a statute of limitations upon the enforcement of such support charges.

HB542—The Term of the Health Commissioner provides to attract and secure a qualified public health officer. Probably refers to the city of Stamford.

HB605—The Transfer of Duties of Collecting for the Care of Patients in State Humane Institutions from the Welfare Commissioner to the State Comptroller because the collection of monies for the care and support of patients in state humane institutions has no relationship to the disbursement of public assistance, the duties involved in such collections are hereby transferred to the state comptroller.

HB624 The Duties of Coroners and Medical Examiners in Investigations of Deaths from Violent or Obscure Causes Including Provisions for Adequate Autopsy and Medicolegal Consultant Service. Identical with SB378.

HB632—Accident Reports — Confidential provides obtaining more accurate reporting of the causes of accidents. If the person reporting knows that the statements contained therein are confidential and cannot be used against him, such person will more accurately report the facts than he will if he knows that such reports are not confidential.

HB633—Commitment Proceedings since the 1953 general assembly repealed provisions for towns paying for the support of persons in state hospitals, this section should be amended to reflect this.

HB647—The Segregation of Defective Delinquents provides to remove from the statutes a sixteen-year-old law which has never been implemented. The section to be deleted reads, "The term 'defective delinquent,' as used in this chapter, shall mean any person who is found to be of defective mentality but not mentally ill and who has committed a criminal act. The term 'vicious feeble-minded,' as used in this chapter, shall mean any person who is found to be feeble-minded and of vicious tendencies."

HB672 and 663—To Regulate the Solicitation of Contributions for Charitable Purposes by Professional Fund Raisers and Solicitors to require the registration with the state welfare department of professional fund raisers and solicitors who conduct campaigns for charitable organizations.

HB665—The Regulation of Solicitation of Funds by Charitable Organizations to require that charitable organizations file certain information with the state welfare department and to make such information a public record.

HB681—Qualification for Unemployment Compensation of Women After Childbirth to require employers to agree to reemploy women leaving work by reason of pregnancy and childbirth.

HB691—Liability Insurance of Motor Vehicle Owners and Operators to require liability insurance for motor vehicle owners and operators.

HB707—Providing for the Licensing of Practical Nurses to enable unlicensed practical nurses to take the examination for certification as licensed practical nurses.

HB708—Notification of Appointment of Directors

of Health provides that one of the duties of the secretary of the state and the clerk of the probate court is the certification of signatures of registrars of vital statistics on certified copies of vital records. Section 643c of the 1953 supplement to the statutes provides for the filing of the names of elected registrars, but does not provide for the filing of the names of the five directors of health who by town charter are also the registrar of births, marriages and deaths of the town. Provisions should be made by appropriate legislation for (1) the filing of these names with the secretary of state and clerk of the probate court and (2) the certification of these directors of health by the secretary of the state and clerk of the probate court.

HB732—The Duties of the State Welfare Commissioner and the Delegation of His Authority to Municipal Welfare Departments provides that since the program of aid to the permanently and totally disabled was passed by the 1953 general assembly subsequent to the passage of these two sections, they should be amended to reflect the existence of this program.

HB734—Payments for Aid to Dependent Children provides to permit certain direct payments for other than medical care, to vendors and suppliers of goods and services. Such payments, in emergencies and in special situations would include moving expenses, terminal rent, care of children while mother was in hospital or too ill to care for home. A similar provision is now in the old age assistance law.

HB735—Support in State Humane Institutions provides to relieve grandparents and grandchildren of patients in state humane institutions of liability for their support; to reduce charges for patients at Mansfield State Training School and Southbury Training School of educational charges; and to repeal the reimbursement provisions against relatives of patients in state humane institutions.

HB873—The Health and Physical Examinations of Public School Employees provides to protect the health of children.

HB897—State Aid for Public Health Nursing provides to raise the minimum limit in average tax receipts whereby towns are eligible to receive state aid for public health nursing.

HB980—Temporary Licenses for Practical Nurses provides to make available to the public the services of adequate practical nurses whose training does not fit into the pattern or requirements now called for by law.

HB1041—Catastrophic Illness provides to protect all persons in the state against the disaster of a catastrophic illness which would use up their financial resources and disrupt family life. To make it possible for doctors and hospitals to give required medical care with an assurance of payment in catastrophic illness.

HB1042—Powers and Duties of Commissioner provides to protect the confidential nature of State employees health records in the files of the Health Services for State Employees.

HB1086—Factory Inspection provides to permit the labor commissioner to issue regulations concerning the

health of employees in places of employment so as to clarify the present powers of the commissioner.

HB1088—Workmen's Compensation—Notice of Injury provides to require that the company provide the employee or his representative with all medical report concerning his condition.

HB1091—Workmen's Compensation—Compensation for Death Resulting from Accident or Occupational Disease provides compensation for life to a widow or widower of a deceased employee, to increase the compensation payable to dependents, and to increase the weekly payments to sixty-six and two-thirds per cent of the wage up to fifty dollars per week.

HB1116—Connecticut Unemployment Sickness and Disability Compensation Act provides to compensate in part for the wage loss sustained by individuals unemployed because of sickness or injury and to reduce the suffering caused by unemployment therefrom.

HB1126—Workmen's Compensation—Rehabilitation provides for the rehabilitation of injured workers by suitable employment and rehabilitation treatment.

HB1135—Compensation for Time Lost While Receiving Medical Treatment provides to compensate injured workers for time lost while undergoing medical treatment.

HB1177—The Use of Drugs or Instruments to Prevent Conception provides to remove the prohibition on physicians in prescribing the use of contraceptives. Birth Control Bill.

HB1182—The Rights of Licensed Physicians to Prescribe for Married Women permits physicians to prescribe and others to use and sell contraceptive devices. Birth Control Bill.

HB1207—Admission of Mentally Ill Persons to Hospital allows medical officers in the Armed Forces and the Public Health Service in interstate transfers to sign statements that they are of the opinion that persons are mentally ill and need treatment in a hospital for mental illness.

HB1208—State Payments to Private Hospitals provides for inclusion of private hospitals under the provisions of state payments.

HB1206—Transferring Neglected and Uncared-For Children to the Welfare Commissioner transfers neglected and uncared-for children to the welfare commissioner, to implement the purposes of the report of the so-called MacDonald Commission.

Senate

SB17—The Illegal Obtaining of Certain Drugs provides for penalties against persons illegally obtaining barbiturates. From Legislative Council.

SB19—The Unlawful Use of Narcotics provides penalties for the unlawful use of or addiction to narcotic drugs without prescription or obtains prescriptions from two or more physicians at the same time without disclosing the fact. From Legislative Council.

SB24—Return and Commitment of Persons Leaving Tuberculosis Sanatoria would protect the public from the danger of infection of alcoholic or recalcitrant persons afflicted with tuberculosis by providing for recommitment of such persons after leaving or escaping state institutions. From Legislative Council.

SB25—Segregation of Defective Delinquents and Aggressive Sexual Deviates provides for the confinement, under indeterminate sentence, of defective delinquents, including aggressive sexual deviates. From Legislative Council.

SB26—Support in State Humane Institutions provides charges to patients in state institutions and other liable persons as investigation discloses they are able to pay at the time of treatment, without further liability. Also includes provision to exclude the cost of education for Mansfield and Southbury Training School patients in calculating charges. Grandparents and grandchildren would be excluded from the list of legally liable relatives who are now charged for support of patients in state institutions. From Legislative Council.

SB27—Establishing a Committee for the Review of Cases of Defective Delinquents and Aggressive Sexual Deviates provides for establishment of a committee of psychiatrists to review cases of defective delinquents and aggressive sexual deviates. From Legislative Council.

SB29—The Possession of Hypodermic Syringes and Instruments provides for the restriction of possession and sale of hypodermic syringes, needles and other instruments adapted to the use of narcotic drugs by subcutaneous injection. Requires that physicians issue permits for the possession of hypodermic syringes and needles. Such permits to be issued under regulations established by the Connecticut Medical Examining Board and on forms provided by the Board. From Legislative Council.

SB32—Bonds of Medical Examiners provides for the filing by medical examiners and assistant medical examiners of a single bond in the amount of one thousand dollars regardless of the number of municipalities which such examiners may be appointed to serve.

SB38—Narcotics provides to conform state provisions concerning narcotics with the federal narcotics act, to remove certain obsolete provisions and to establish a minimum penalty for a second offense of furnishing drugs to minors. From Legislative Council.

SB39—The Commitment of Drug Addicts provides for immediate hospitalization of drug addicts where required. From Legislative Council.

SB40—Authorizing the State to Enter Into the New England Board of Higher Education Compact provides to authorize the state to enter into the New England Board of Higher Education Compact. From Commission appointed to inquire into establishment of a New England Regional Medical School.

SB47—Providing for a Medical-Dental School at the University of Connecticut provides for the construction of a medical and dental school in Hartford as a part of The University of Connecticut. Includes a bond issue of six million dollars for original construction. Does not in-

clude authorization for agreement or negotiations to provide hospital or clinical facilities.

SB48—The Adoption of An Interstate Compact for the Establishment of the New England Board of Higher Education. Identical with SB40.

SB62—Manufacture, Sale and Use of Milk Bottles allows use of gallon and half-gallon milk bottles.

SB78—Establishing a Narcotics Division in the State Police Department provides for a narcotics division in the state police department for more effective enforcement of the narcotics laws.

SB114—The Education, Welfare and Public Health Tax provides for the removal of the termination date of the present rate of the education, welfare and public health tax. (State sales tax.)

SB148—Patients in State Tuberculosis Sanatoria provides for state care for patients in state tuberculosis sanatoria except where covered by Workmen's Compensation or insurance.

SB149—Support of Dependents provides to enable the Veterans Home and Hospital Commission to pay dependents of veterans not to exceed fifteen dollars and ten dollars weekly instead of the present allowances of ten and six dollars weekly as the present allowances are unrealistic with respect to the present cost of living. Amending Section 2934, General Statutes.

SB156—Unemployment Compensation; Disqualifications; Pregnancy and Childbirth provides unemployment compensation benefits within two months before childbirth and two months after childbirth.

SB164—Acceptance of Gifts on Behalf of State Mental Hospitals by the Trustees Thereof, and on Behalf of the Department of Mental Health by the Commissioner Thereof provides authorization of trustees of mental hospitals and the Connecticut Child Study and Treatment Home to accept gifts, and to authorize the commissioner of mental health to do the same with respect to the department of mental health.

SB165—Ownership of the State Mental Hospitals, and Prescribing the Manner in Which Lawsuits Involving the Same Are to be Conducted provides to make uniform, and consistent with the purposes of Sections 1164c through 1172c of the 1953 Supplement to the General Statutes, 1949 Revision, the provisions relating to ownership and administration of, and conduct of lawsuits involving, the state mental hospitals.

SB166—The Rights of Patients in Hospitals for Mental Illness provides to establish and define certain rights of patients in hospitals for mental illness with regard to care and treatment, use of mechanical restraints and communications with persons inside and outside the hospitals.

SB189—Fair Educational Practices provides equal educational opportunity for all persons without discrimination because of race, color or creed in our non-denominational, tax exempt schools and colleges.

SB196—Exemptions from the Education, Welfare and Public Health Tax provides exemption of all medi-

cines and soaps from the education, welfare and public health tax. (Sales tax.)

SB197—Sales Tax Exemptions provides for exemption of packaged patent medicine and baby oils, lotions and powders from the sales tax.

SB251—Providing a Blood Test in Bastardy Cases provides a blood test in bastardy cases.

SB285—Establishing a Catastrophic Illness Study Commission provides to establish a commission to study the problems of catastrophic illness.

SB288—Physical Examinations and Compensation for State Employees provides for full pay for a state employee who contracts a contagious disease in the course of his employment.

SB293—Support in the Mansfield State Training School and Hospital and in the Southbury Training School provides a basis for determining costs of support in the Training Schools and fixing a maximum charge of \$40 per month.

SB333—Sales Tax—Exemptions provides exemption from the sales tax the sale of artificial aids and appliances since it seems an unnecessarily heavy burden for disabled people to have to pay a sales tax on the aids or appliances they need.

SB361—Regulations Under the Uniform Narcotic Drug Act provides for the state department of health to adopt regulations in order to conform with the provisions of the Uniform Narcotic Drug Act with the federal act and regulations promulgated thereunder, in accordance with the suggestion of the attorney general's office.

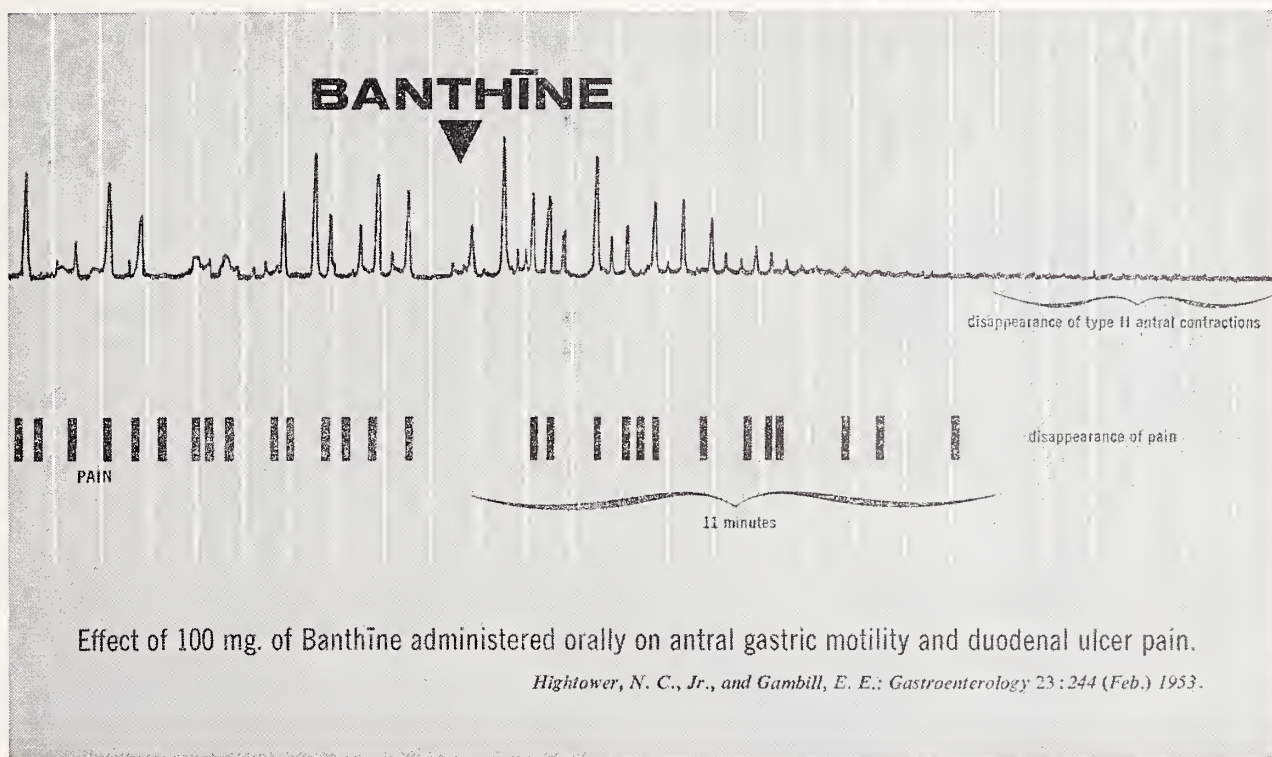
SB378—The Duties of Coroners and Medical Examiners in Investigations of Deaths from Violent or Obscure Causes Including Provisions for Adequate Autopsy and Medicolegal Consultant Service provides for clarification of procedure to be followed by coroners and medical examiners in the performance of their duties and to provide for adequate and effective autopsy service and medicolegal consultant service to coroners, medical examiners, police and prosecuting officials. Note: Section 4 does not require that the chief state pathologist be licensed to practice medicine in Connecticut.

SB405—Hospital and Public Health Center Survey and Construction provides to carry out the requirement of Title VI, Construction of Hospitals, of the Public Health Service Act, Section 623 (a) (1), namely, to "designate a single state agency as the sole agency for the administration of the plan . . ." and to make this effective for recent amendments and all possible future amendments.

SB406—Detention of Radioactive Persons by State Department of Health provisions in this section give the state department of health the power to confine persons who because of contamination with radioactive material are a hazard to public health and the authority to contract for such places of confinement as are necessary to the detention of these persons.

SB407—Confinement of Radioactive Persons: Quarantine of Certain Persons the confinement of contam-

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The effect on motor activity is generally more pronounced and less variable than on secretion; pain relief is usually prompt; a high degree of effectiveness is noted in ambulatory ulcer patients.

Ruffin, J. M.; Texer, E. C., Jr.; Carter, D. D., and Baylin, G. J.: J.A.M.A. 153:1159 (Nov. 28) 1953.

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inated persons until radiation is lowered to safe limits is necessary to prevent public exposure. This statute will give the director of health or board of health of a town, city or borough the same authority to confine these persons as is given him to confine cases of communicable disease.

SB429—A Commission for Problems of Aged Citizens provides to survey the situation of our aged citizens in order to find out how best to meet their housing and recreational needs.

SB430—Licensure of Hospitals and Homes for the Aged. During the 1953 session of the state legislature there was some confusion in regard to statutes governing licensure of hospitals and homes for the aged. This was due to the abolition of the Public Welfare Council and the transfer of some of its duties and responsibilities to the Department of Health. The result was three statutes with some overlapping of purpose and intent—1) Section 1545c and section 1546c re: licensure of hospitals; 2) section 1621c re: licensure of homes for the aged; and, 3) sections 1550c through 1560c re: licensure of institutions. Sections 1550c through 1560c were designed to govern licensure of all types of eligible institutions; they were passed, however, after sections 1545c, 1546c and 1621c had become law.

The use of certain special facilities in hospitals creates hazards to hospital personnel and to the public which require more than minimum hospital requirements to assure that the health of hospital personnel and the public is protected. This statute (section 6) will give the state department of health the power to define in the sanitary code such additional requirements as are necessary to assure the safe utilization of ionizing radiation.

The above is an effort to compile the essentials of all these statutes in one comprehensive law to direct the licensure of hospitals and homes for the aged by the State Department of Health.

SB431—Detention of Mentally Ill Persons Prior to Commitment; Boarding Homes for Mentally Ill and Mentally Defective Persons. Sec. 1 provides transfer from the commissioner of health to the commissioner of mental health the responsibility for receiving reports concerning persons admitted to private hospitals for mental illness. Sec. 2 provides transfer the responsibility for licensing boarding homes for mentally ill and mentally defective persons from the state department of health to the state department of mental health.

SB432—Allocation of Liquor Permit Fees to the Inebriate Fund to increase the allocation to twenty per cent of liquor permit fees to the inebriate fund.

SB433—Inspection and Licensing of Hospitals and Institutions for the Care of the Mentally Ill provides transfer of responsibilities of inspection and licensing of private mental hospitals from the state department of health to the state department of mental health.

SB435—Transferring the Duties of the County Commissioners as to Neglected and Uncared-For Children to the Welfare Commissioner provides transfer of duties of the county commissioners in connection with child welfare to the welfare commissioner.

SB436—Old Age Assistance provides treating all applicants equally, to eliminate the pauperizing features of the present law and to minimize the cost of administration.

SB479—To Ratify the New England Higher Education Compact and Defining the Connecticut Membership on the Regional Board because of the developments already in prospect as indicated and in recognition of the fact that further expansion of higher education in New England will certainly involve the state-supported institutions, the six New England Land-Grant State Universities are recommending to the several state legislatures precisely the same language as contained in this act and with specific reference to defining the membership on the regional board.

SB483—Authorizing the Erection and Operation of an Educational Television Station authorizes the state board of education to establish and maintain an educational television station and to make appropriations for the purpose thereby assuring that one of the present allotment of three ultra high frequency channels to Connecticut for educational purposes will be made secure and not lost.

SB535—Hypertension or Heart Disease of Policemen and Firemen extends the presumption of hypertension and heart disease being connected with employment of firemen and policemen in case of death.

SB544—Workmen's Compensation — Payment to Employees for Artificial Aids Damaged in the Course of Employment provides to pay for artificial aids damaged by accident in course of employment.

SB549—Connecticut Unemployment Sickness and Disability Compensation Act. Identical with HB1116.

SB553—Connecticut Unemployment Sickness and Disability Compensation Act. Identical with SB549 and HB1116.

SB563—A Hearing by the Workmen's Compensation Commissioner Before Voluntary Payments Can be Discontinued provides a hearing by the Workmen's Compensation Commissioner before payments are terminated

SB576—Subpoena of Hospital Records makes hospital records available in court without the attendance of hospital personnel.

SB580—Fees Paid by Coroners increases the fee paid for external examination from ten to fifteen dollars.

SB581—The Practice of Chiropody defines the Practice of Chiropody in conformity with present day practice.

SB602—Certain Statements of Fact or Opinion Admissible in Evidence in Cases of Contract or Tort for Malpractice facilitates proof in malpractice cases.

SB656—Catastrophic Illness. Identical with HB1041.

SB657—Charges for Care at Facilities of the Commission on Chronically Ill, Aged and Infirm repeals provisions for charging for care and treatment in facilities maintained by the Commission on Chronically Ill, Aged and Infirm.

SB659—Support in State Institutions provides for support by the state of patients in state mental hospitals, training schools and tuberculosis sanatoria.

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digestive difficulties

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NEWS

from County Associations

Fairfield

Charles B. Gaffney was installed as president of the staff of St. Vincent's Hospital at the annual banquet of the staff held on February 1 at Champs Restaurant in Bridgeport. Other officers appointed for the year were Joseph C. Quatrano, vice-president and R. Edward Vioni, secretary-treasurer.

D. Olan Meeker of Riverside was the speaker at the winter meeting of the Litchfield County Medical Association in January. Dr. Meeker is chairman of the Committee on National Legislation.

The Bridgeport Medical Association held the annual banquet of the Association at the Fairfield Inn in Fairfield on January 19. Installed as president was Edward P. Kemp. Other officers for the year are Edwin R. Connors, president-elect; Frank Turchik, vice-president; Joseph V. DeLuca, secretary and Joseph G. Hennessey, treasurer. Members of the Council announced by the president were: Irwin S. Eskwith, Maurice Kaufman, Michael A. Dean, Joseph C. Quatrano, Thomas F. Davis, J. Grady Booe, Charles B. Gaffney, R. Edward Vioni, Michael J. Cardone, Joseph M. Adzima, John F. Nolan and Charles W. Nichols.

Maxwell Bogin, chief of the Department of Pediatrics at Bridgeport Hospital was elected to the presidency of the staff of Bridgeport Hospital in February, Nathan H. Friedman was appointed vice-president and Louis Castaldo will serve as secretary.

Edward P. McCreery and Roland T. Wehger attended the annual meeting of the American Academy of Orthopedic Surgeons in Los Angeles in January.

William Frank Gordon, a practising physician in Danbury for almost sixty years, died at his home in that city on February 10. Dr. Gordon was honored in 1949 for his record of 50 years membership in the State Medical Society.

Hartford

Hartford Hospital now has its fourth administrative intern, Gordon McWilliams formerly of Pitts-

field, Massachusetts. Mr. McWilliams is a graduate of Williams College and attended University of Massachusetts for two years taking a course in business and science. He served in the U. S. Army and later took a position at Pittsfield Hospital in Pittsfield, Massachusetts. He recently took the course in hospital administration at Columbia University. Mr. McWilliams is married.

Newell R. Kelley of Windsor, assistant medical director of the Phoenix Mutual Life Insurance Company for the past seven years, has been appointed associate medical director of Bankers Life Company, Des Moines, Iowa. Before joining Phoenix Mutual Dr. Kelley was engaged in general practice in Rocky Hill. He was a former intern at Hartford Hospital.

Among the hospitals: The director of Mt. Sinai, Dr. I. S. Geetter, has recommended to his Board of Directors that the hospital be expanded from 115 beds to 165 beds at once to handle increased patient demands. Bristol Hospital has been accredited by the AMA for intern training. The hospital has also secured the services of Dr. Donald E. Rowley as part-time educational director. Hartford Hospital has begun a new research project to study the blood enzyme, choline-esterase. This new research project will be guided by Dr. Howard Wetstone. Dr. Benjamin White is his sponsor in the project.

William H. Van Strander, formerly chief of the x-ray department at St. Francis Hospital, Hartford, died February 13 at the Hospital. Dr. Van Strander was a 50 year member of the State Medical Society.

Litchfield

The Litchfield County Medical Association Mid-winter Meeting was held at the Conley Inn in Torrington on January 25. The business meeting was preceded by a social hour and a roast beef dinner. Fifty members and guests were present.

Since Dr. Barker was unable to be present, Thomas A. Danaher, chairman of the Council, discussed numerous situations pertaining to the State Society. Among these was the need for a change in the county by-laws to bring them in accord with the recent changes in the State Society by-laws to provide for a councilor and an alternate councilor, each serving a two year term and each having a vote in the Council. He also discussed very briefly bills pertaining to medicine that have been or are expect-

ed to be acted upon by the State Legislature. A separate committee has been appointed by the Council to study the bill which proposes the establishment of a medical school in Connecticut. Dr. Danaher also gave some exceedingly interesting figures concerning the growth of Connecticut Medical Service. CMS paid, in 1954, \$6,000,688 in claims and now processes 528 claims every working day. Membership at present is 866,000, and this is compared with 697,000 members as of one year ago. A total of \$21,000,000 has been paid in claims to date. He outlined certain changes that are to be made in the composition of the professional policy committee. This will be given in detail in the near future in the JOURNAL.

William G. H. Dobbs, chairman of the State Committee on Public Relations, reported for that committee and made some suggestions as to how we, on the county level, could improve our public relations. He also appealed for greater participation of county physicians in behalf of the American Medical Education Foundation. He pointed out that there is a \$10,000,000 annual deficit in operating our eighty medical schools, and that this deficit must be made up by the physicians of the country if we do not expect the government to step in and fill this gap. The burden at present is being carried by a very small percentage of the physicians, and he urged that every member contribute to this very worthy cause.

Two amendments to the by-laws were adopted. The speaker of the evening was D. Olan Meeker of Greenwich. Dr. Meeker held the attention of his audience for more than an hour, discussing "Legislation, Past and Future." He proved to be an exceedingly able speaker and the members of the Association were greatly enlightened as to legislation that had been presented in the past and other legislation that was due to be acted upon in the future which widely affects all of us in the practice of medicine.

Middlesex

F. Erwin Tracy attended a meeting of the New York Academy of Science in January at which a symposium on new developments in the use of steroids was held.

Benjamin Roccapriore has just become a member of the Middletown Board of Health. He replaces James Murphy who retired.

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New Haven

At the annual meeting of the Waterbury Medical Association, the following officers were nominated: President, Samuel Fabricant; Vice-President, O. J. Bizzozero; Treasurer, Harold Morrill; Secretary, Louis Olore; Assistant Secretary, William Arnold, Jr., and Librarian, Sidney Jennes.

At the monthly meetings of the Waterbury Medical Society a brief report is read of the past meeting of the Board of Governors of the New Haven County Medical Association. This has been a most worthwhile inauguration, since it keeps local members better informed of events at the county level.

At the monthly scientific meeting of the Waterbury Area Heart Association, held February 3, Max G. Carter, chief of thoracic and cardiovascular surgery at the Hospital of St. Raphael, New Haven, spoke on "The Surgery of Mitral Stenosis."

New London

The regular monthly meeting of the staff of the W. W. Backus Hospital was held in Norwich on January 13. The speaker for the evening was William J. Neidlinger of Hartford Hospital who spoke on "The Nose—In Health and Disease."

The monthly dinner lecture meeting of the Lawrence and Memorial Hospital was held January 20. The speaker was Louis Selverstone, assistant professor of medicine at Tufts University Medical School and attending physician at the New England Center Hospital, who spoke on "Aspects of Pericarditis."

A Child Guidance Clinic of Southeastern Connecticut was recently formed in New London. The group is made up of civic minded persons. Several local doctors are members of the society. A monthly meeting is planned. The last meeting was held January 25 at the Nathan Hale School Library. The speaker was Elias J. Marsh, director of the Bureau of Mental Hygiene, who spoke on "How Can a Clinic Best Serve This Community."

The New London Chapter of the Connecticut Heart Association had Stanford Wessler speak at the Lawrence and Memorial Hospital on the "Management of Thromboembolism," on January 27.

The regular monthly meeting of the New London County Medical Association was held February 3 at the Uncas-on-Thames Sanatorium. The speaker was John Lenard, director of medical education, Hartford Hospital. His topic was "Use and Abuse of Antibiotics."

NEW BOOKS IN REVIEW

CURRENT CONCEPTS IN DIGITALIS THERAPY. By Bernard Lown, M.D. and Samuel A. Levine, M.D. Boston: Little, Brown and Company. 1954. 164 pp. \$3.50.

Reviewed by CHARLES E. McLEAN

This is a concise, well written book designed to give a practical accounting of the properties and uses of today's commonly employed digitalizing agents. The discussion of digitalis intoxication emphasizes several important aspects that are not commonly considered and reminds us once again of the rising incidence of toxicity with the introduction of the purified glycosides. Of particular importance is the chapter on electrolytes and digitalis in which the close relationship of potassium and other electrolytes such as calcium and magnesium are discussed. The self-redigitalization syndrome following the use of mercurial diuretics and the part played by postassium, both in its production and in its treatment, is described. Paroxysmal atrial tachycardia with block as a symptom of digitalis intoxication is dealt with in detail together with the use of Procaine amide in the treatment of digitalis toxicity. And finally an interesting digitalis tolerance test using Acetyl strophanthidin is included. This is illustrated by several interesting case histories in which this technique proved to be of considerable value in determining whether the patient receiving digitalis was in need of more, or was intoxicated with the drug.

Much of the material in this book has already appeared in the *New England Journal of Medicine* but interest in the papers was so great that the authors decided to publish it in monograph form. This book is well worth the reading for anyone interested in the treatment of heart disease.

ATLAS OF MEN. By William H. Sheldon, PH.D., M.D., Director of the Constitution Laboratory, College of Physicians and Surgeons, Columbia University, New York and the University of Oregon. With the collaboration of C. Wesley Dupertuis, PH.D., School of Medicine, Western Reserve University and Eugene McDermott, M.A., Dallas, Texas. New York: Harper and Bros. 1954. 357 pp. \$10.

Reviewed by CHARLES W. GOFF

At long last an Atlas of Men is available containing 357 pages, of a large size so that adequate illustrations can be included on a single page, showing 1,175 body build or somatotypes, together with a number of other illustrations and three appendices. A monograph and tables, as well as several diagrams are included, which enable the average individual to compute a body build from the stature and weight determinations without much difficulty. In applying the index which is obtained on the monograph readings, consisting of the height divided by the cube root of the weight, there are usually three and sometimes four choices. Here the goodness of fit is made much more accurate for the user of the Atlas by turning to these three or four different types and comparing the photographs with the actual individual who is being typed.

The stated principle and purpose of the Atlas of Men have been achieved by its authors. By making available a standard file of somatotype variations (body build) a prac-

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J. Pediat. 44:386, 1954.

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Brit. M. J. 2:755, 1953.

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Brown, H. W.:
J. Pediat. 45:419, 1954.

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tical tool is thus presented to a research scientist in genetics, clinical medicine and social studies. Whether it is later to be modified, scarcely matters today. We know that every phase of science is subject to constructive changes. The quibble as to where the particular genotypes fit in with the somatotypes must be left to the physical anthropologists who are most interested in this phase. Actually, we now have in this Atlas a controlled series against which we can plot those that appear in our clinical studies. It is true that this is largely a cross sectional Atlas but a longitudinal Atlas, as the authors state, while more desirable, is next to impossible as an achievement. Since clinicians are concerned with comparing and correlating their group studies with those of other investigators, and have hitherto found it almost impossible to compare purely descriptive texts, they now have a means of accurately comparing their cases with the cases of other study groups.

Human variations are enormous, or so they seem, until a descriptive classification, or a taxonomic method is set up by a body build expert, such as the authors undoubtedly are. Here, many differences are reduced with great skill to a manageable, numerical determination. Sheldon and his co-workers have divided man into valid body type units of 88 somatotypes on the 7 point scale. There were 505 body types when they used the one-half scale or a 13 point rating. They have arranged them in their frequency as they

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occurred in their series of 46,000 male subjects that were photographed between the ages of 18 and 65 years. Incidentally, children may be typed but to date their classification has not been reported.

Normal curves for height, weight and age are given and the incidence per 1,000 individuals is listed. This alone will be of great value to the clinician, especially in the projectional fields of life, accident and health insurance. Every medical director of every insurance company will find these materials more valuable than any of the older tables, which they have considered their abacus when deciding where "applicants" should be placed.

Some will criticize the zoological classification which the authors have used but I rather like it. The manner of diagramming a three dimensional component is excellent and

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the curves are of great value. The authors have thrown in for good measure in the last paragraph under each worded description, very valuable information relative to the particular body type in question as has come to their hand. This will be deeply appreciated by clinicians but must be taken with the reservation that the particular individual typed by them in their own series may show other characteristics.

I do not wish to go into the validity of their terminology except to say that anthropologists are struggling with this phase of somatotyping. Hope exists that they will deliver themselves of a fruitful conclusion. This Atlas will stand on my desk for all times, until a better is forthcoming.

THE CIBA COLLECTION OF MEDICAL ILLUSTRATIONS. Volume 2. A Compilation of Paintings on the Normal and Pathologic Anatomy of the Reproductive System. Prepared by *Frank H. Netter, M.D.* Edited by *Ernst Oppenheimer, M.D.*, with a foreword by *John Rock, M.D.* Summit, N. J.: Ciba Pharmaceutical Products, Inc. 1954. 302 pp. \$13.

Reviewed by STANLEY B. WELD

This volume portrays the major anatomy and pathology of the reproductive system with color plates, each one occupying part or all of a page and accompanied by a detailed description by one or more eminent physicians. The artistic work is the product of Dr. Frank H. Netter who, according to Dr. John Rock, "blends real beauty of color and composition with ingenuity in three-dimensional depiction of even particulate morphology."

Three-fourths of the pages portray pathology of both primary and secondary male and female sex organs, which taken together add to the value of the volume and to its usefulness to the medical student and clinician.

Ciba is to be complimented on furnishing such a beautiful volume, superbly bound and furnished at cost.

THE CITY OF HOPE. By *Samuel H. Golter.* New York: G. P. Putnam & Sons. 1954. 189 pp. \$3.50.

Reviewed by STANLEY B. WELD

Some evening when you have returned from a difficult day which included a disillusioning experience with another human being, possibly a patient, you should have this book at hand. You may start reading it with a bit of a feeling of skepticism because of its title and its author, a Jewish immigrant from Russia in the days of the Czarist regime. But as you continue to turn the pages you will gain new hope and perhaps renew your faith in your fellowman, for here was a poor immigrant boy fired by an ideal for which he worked day and night. He gave of his own strength till he was stricken down with cancer; he succeeded in getting others to give and the final result from the small beginning of a mere tent in the desert for the victims of tuberculosis is a large institution for the care of people with tuberculosis, cancer and kindred diseases, and for the advancement of research in a fight against cancer, tuberculosis, leukemia and heart disease. All this free to the patient who has no means with which to meet the costs!

It seems incredulous that one man should be able to accomplish so much, and yet there it stands, the City of Hope, a

nonsectarian medical center, operated under Jewish auspices and supported by people in all walks of life, of every race, religion and creed.

The book is a great tribute to one man's unselfish enthusiasm.

DISABILITY EVALUATION. PRINCIPLES OF TREATMENT OF COMPENSABLE INJURIES. (5th Edition.) By *Earl D. McBride, B.S., M.D., F.A.C.S.*, Assistant Professor in Orthopedic Surgery, University of Oklahoma School of Medicine; Attending Orthopedic Surgeon to St. Anthony's Hospital. Philadelphia: J. B. Lippincott Co. 1953. 715 pp. \$7.50.

Reviewed by C. W. GOFF

Any monograph, large or small, especially one pertaining to ratings of disabilities and their treatment, that is in its fifth edition needs no further compliments. This book has and always will stand on its own merits. There are 715 pages with 375 figure drawings or plates. There are many tables and formulae for obtaining ratings for purposes of settling industrial injuries as related to their end results. From the title it is apparent that most injuries are potential sources of some permanent disability. In this regard, the author comes to grips with his problem immediately by stating that a satisfactory blanket schedule of partial permanent disability ratings, inclusive of all the other anatomic and functional variations, is not to be had. He does root for standardization through the uniformity of some basic schedule. This schedule is presented by means of a colored section within his monograph for easy reference. His ratings are based upon a long experience and a thorough study of the schedules throughout the United States. In this regard he has been a consultant in the recodification of Workmen's Compensation statutes in some of the Western and Southwestern States. His methods of appraisal cannot be discussed in a short review but it must be added that the schedules of gradations seem extraordinary sound. While it is necessary to have a pencil for purposes of computing sums in using his system, it is nevertheless not at all difficult to do. Most physicians abhor mathematics and may look at his formulae for computing these disabilities with some horror at first glance. Please study a little deeper into the workings of his system and learn how useful it can be and, above all, how relatively easy it is to compute instead of using "by guess and by God" system that so many physicians use in reaching their ratings. Furthermore, this volume is recommended as a working tool for every Compensation commissioner in the country. All judges who see personal liability cases should be familiar with its workings. I doubt if they will be but, nevertheless, they should be. It is high time that libraries are available to jurors when they sit in contemplation of the fates of people and property in courts. This volume should be on the five foot shelf of every jury room. Furthermore, it should be on the desk of every orthopedic and traumatic surgeon, as well as in the offices of all insurance companies. This must be why it has survived into its fifth edition. This reviewer cannot recommend it too highly. Earl McBride has assembled old compensation wine and dispensed it in new bottles and what a delectable concoction it turned out to be!

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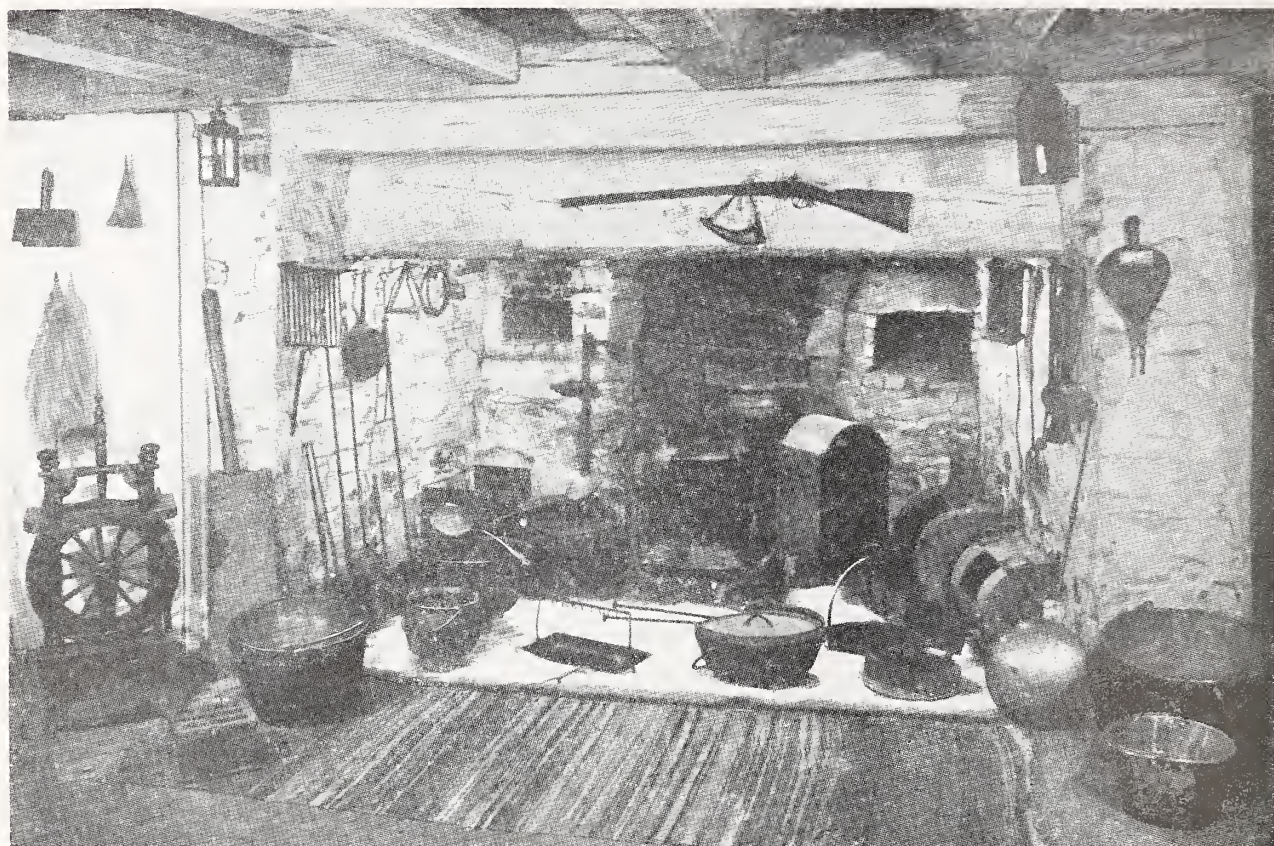
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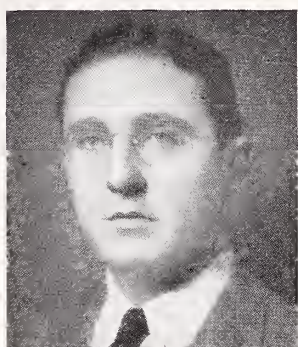
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Tuesday, April 26

MUSIC ROOM

ANNUAL MEETING OF THE HOUSE OF DELEGATES

COLE B. GIBSON, *Meriden, Speaker of the House, presiding*

10:00 CALL TO ORDER

BUSINESS SESSION

1:00 LUNCHEON FOR OFFICERS, MEMBERS OF THE HOUSE, AND GUESTS

2:00 RESUMPTION OF BUSINESS

7:00 ANNUAL DINNER OF THE COUNCIL—The Council will hold its annual dinner for the Program Committee, the Local Committee on Arrangements, and guests, at the Stratfield Hotel, Bridgeport



STRATFORD CENTER IN 1880

Wednesday, April 27

9:00 REGISTRATION—Exhibit Hall

AUDITORIUM

9:15 MOTION PICTURE FILM—"CONGENITAL MALFORMATIONS OF THE HEART"

9:30 CALL TO ORDER—President of the Society

ADDRESS OF WELCOME—Edwin R. Connors, Bridgeport, Chairman, Local Committee on Arrangements

H. M. MARVIN, New Haven, presiding

10:00 PRACTICAL PROBLEMS IN THE CARE OF THE AGED

Frederic D. Zeman, New York; Chief of Medical Service, Home for Aged and Infirm Hebrews, New York; Lecturer in Medicine, College of Physicians and Surgeons, Columbia University

10:35 NONSPECIFICITY OF THE ELECTROCARDIOGRAM IN CORONARY ARTERY DISEASE

Harold D. Levine, Boston; Associate in Medicine, Peter Bent Brigham Hospital, Boston; Clinical Associate in Medicine, Harvard Medical School

11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS

SAMUEL D. KUSHLAN, New Haven, presiding

11:40 VISUALIZATION OF THE BILIARY TRACT, BEFORE AND AFTER CHOLECYSTECTOMY, WITH THE NEW INTRAVENOUS CONTRAST MATERIAL (CHOLOGRAFIN)

Herbert M. Stauffer, Philadelphia; Professor of Radiology, Temple University School of Medicine; Associate Radiologist, Temple University Hospital

12:15 THE DEPRESSED OFFICE PATIENT

Paul H. Hoch, New York; Assistant Professor of Psychiatry, College of Physicians and Surgeons, Columbia University; Principal Research Psychiatrist (Director of Research), New York State Psychiatric Institute

1:00 LUNCHEON—Cafeteria of the High School

VISIT TO TECHNICAL EXHIBITS

PROGRAM ARRANGED BY

CONNECTICUT CHAPTER—AMERICAN ACADEMY OF GENERAL PRACTICE

President: Julius H. Grower, *Middletown*

Secretary: Peter J. Scafarello, *Hartford*

2:00 BRACHIAL NEURALGIA—WHAT IS IT OR IS IT?

Darrell C. Crain, Washington, D. C.; Assistant Professor of Clinical Medicine, Georgetown University Medical School; Director of Rheumatology Clinic, Georgetown University Hospital

2:45 PRESENT DAY MANAGEMENT OF HYPERTHYROIDISM

Solomon Silver, New York; Attending Physician, Mount Sinai Hospital; Director of Thyroid Clinic, Mount Sinai Hospital; Assistant Clinical Professor of Medicine, College of Physicians and Surgeon, Columbia University

ANNUAL MEETING PROGRAM

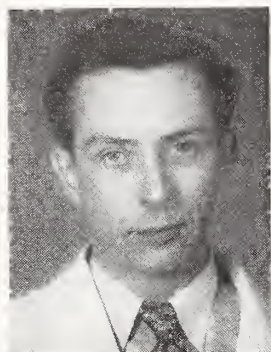
Speakers — Wednesday, April 27



Frederic D. Zeman, New York City; Chief of Medical Service, Home for Aged & Infirm Hebrews, N. Y.; Lecturer in Medicine, College of Physicians & Surgeons, Columbia University.



Harold D. Levine, Boston, Mass.; Associate in Medicine, Peter Bent Brigham Hospital, Boston; Clinical Associate in Medicine, Harvard Medical School, Boston.



Herbert M. Stauffer, Philadelphia, Pa.; Professor of Radiology, Temple University School of Medicine; Associate Radiologist, Temple University Hospital.



Paul H. Hoch, New York City; Assistant Professor of Psychiatry, College of Physicians and Surgeons, Columbia University; Principal Research Psychiatrist, N. Y. State Psychiatric Institute.



Solomon Silver, New York; Attending Physician, Mt. Sinai Hospital; Director of Thyroid Clinic, Mount Sinai Hospital; Assistant Clinical Professor of Medicine, College of Physicians and Surgeons, Columbia University.



Darrell C. Crain, Washington, D. C.; Assistant Professor of Clinical Medicine, Georgetown University Medical School; Director of Rheumatology Clinic, Georgetown University Hospital.

Wednesday, April 27

MUSIC ROOM

9:15 FILM—DYNAMIC POSTURE

Narrator—Beckett Howorth, *Stamford*; *Clinical Professor of Orthopedics, New York University Postgraduate Medical Center; Chief, Orthopedic Department, Greenwich Hospital, Connecticut*

OLIVER L. STRINGFIELD, *Stamford*, presiding

10:00 CONGENITAL ANOMALIES—DISCUSSION OF CAUSATION

Theodore H. Ingalls, *Boston*; *Associate Professor of Epidemiology, Harvard University School of Public Health; Associate Physician, Children's Medical Center, Boston; Associate Editor, New England Journal of Medicine*

10:35 THE OCCURRENCE AND SPREAD OF INFECTIOUS DISEASES IN FAMILIES

William S. Jordan, Jr., *Cleveland, Ohio*; *Associate Professor of Preventive Medicine, Western Reserve University; Assistant Physician, University Hospitals*

11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS

DAVID H. CLEMENT, *New Haven*, presiding

11:40 HORMONES IN MANAGEMENT OF RHEUMATIC FEVER

Gene H. Stollerman, *Irvington-on-Hudson, New York*; *Medical Director, Irvington House; Instructor in Medicine, New York University College of Medicine*

12:15 PROPHYLACTIC MEASURES IN CHILDREN'S ALLERGIES

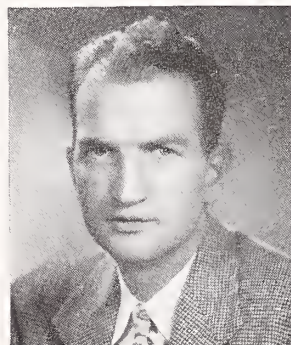
Douglas E. Johnstone, *Rochester, New York*; *Instructor of Pediatrics, University of Rochester School of Medicine and Dentistry; Director of Pediatric Allergy Clinic, Strong Memorial Hospital, Rochester*

1:00 LUNCHEON—Cafeteria of the High School

VISIT TO TECHNICAL EXHIBITS

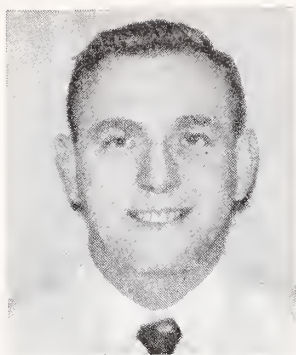


Theodore Ingalls, Boston, Mass.; Associate Professor of Epidemiology, Harvard University School of Public Health; Associate Editor, *New England Journal of Medicine*; Associate Physician, Children's Medical Center, Boston.

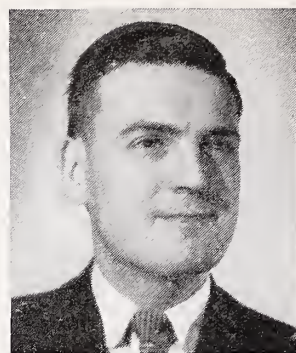


William S. Jordan, Jr., Cleveland, Ohio; Associate Professor of Preventive Medicine, Western Reserve University; Assistant Physician, University Hospitals.

Wednesday, April 27



Gene H. Stollerman, Irvington-on-Hudson, New York; Medical Director, Irvington House; Instructor in Medicine, New York University College of Medicine.



Douglas E. Johnstone, Rochester, N. Y.; Instructor of Pediatrics, University of Rochester School of Medicine and Dentistry; Director of Pediatric Allergy Clinic, Strong Memorial Hospital.

MEETINGS OF SECTIONS OF THE SOCIETY AND GUEST ORGANIZATIONS

WOMAN'S AUXILIARY TO THE CONNECTICUT STATE MEDICAL SOCIETY

ELEVENTH ANNUAL MEETING

BROOKLAWN COUNTRY CLUB, BRIDGEPORT

President: Mrs. Newell W. Giles, *Darien*

Secretary: Mrs. Charles S. Culotta, *Hamden*

10:30 Registration

Business Meeting

11:30 WOMAN'S WORLD AND MEDICAL EDUCATION

John W. Hedback, *Chicago*; Associate Executive Secretary, American Medical Education Foundation

12:00 Social Hour

12:30 Luncheon

Greetings from the National Auxiliary

Mrs. George Turner, President, Woman's Auxiliary to the American Medical Association

1:30 YOU AS AN INDIVIDUAL ARE IMPORTANT

Mrs. Harold Brinig, *New York City*

2:30 Induction of Officers—Mrs. James D. Gold, *Bridgeport*

Presentation of President's Pin—Mrs. Newell W. Giles, *Darien*

Response by Incoming President—Mrs. Norman J. Barker, *Collinsville*

SECTION ON ANESTHESIA

3:30 Room 122

President: Joseph Magnano, *Middletown*

Secretary: Leopold F. Trifari, *Hamden*

ANESTHETIC PROBLEMS IN OBSTETRICS

Virginia Apgar, *New York*; Professor of Anesthesiology, College of Physicians and Surgeons, Columbia University

SECTION ON DERMATOLOGY AND SYPHILOLOGY

3:30 Room 125

President: Albert Levenson, *Bridgeport*

Secretary: Ellwood C. Weise, Jr., *Bridgeport*

PRESENT STATUS OF DERMABRASION THERAPY

Charles R. Rein, *New York*; Associate Clinical Professor of Dermatology and Syphilology, New York University Postgraduate Medical School

Gustave Sirot, *New York*; Graduate Student, Department of Dermatology and Syphilology, New York University Postgraduate Medical School

Wednesday, April 27

JOINT MEETING

3:30 Rooms 120-121

SECTION ON GASTROENTEROLOGY

President: Benjamin V. White, *Hartford*Secretary: Sydney Selesnick, *West Haven*

SECTION ON RADIOLOGY

President: Willard E. Buckley, *Middletown*Secretary: William A. Goodrich, *Hartford*

CLINICAL AND ROENTGEN DIAGNOSIS OF RIGHT UPPER QUADRANT SYNDROMES

Presiding: Ralph T. Ogden, *Hartford*; *Visiting Radiologist, Hartford Hospital*Radiological Aspect: Herbert M. Stauffer, *Philadelphia*; *Associate Professor of Radiology, Temple University School of Medicine*Medical Aspect: Daniel S. Ellis, *Brookline, Massachusetts*; *Assistant in Medicine, Harvard Medical School*Surgical Aspect: Richard Warren, *Brookline, Massachusetts*; *Clinical Associate in Surgery, Harvard Medical School*

SECTION ON PROCTOLOGY

3:30 Room 127

President: Frederick S. Ellison, *Hartford*Secretary: Angelo L. Gentile, *New Haven*

PROBLEMS OF THE COLON AND RECTUM FROM THE GENERAL PRACTITIONER'S VIEWPOINT

Maurice T. Root, *Hartford*; *Visiting Physician and Chief of Staff, Hartford Hospital*

CONNECTICUT SOCIETY FOR PSYCHIATRY AND NEUROLOGY

3:30 Room 223

President: Bernhard A. Rogowski, *New Haven*Secretary: Sidney Berman, *New Haven*

THE RENAISSANCE OF NEURO-PSYCHIATRY

Louis Linn, *New York*; *Department of Psychiatry, Mt. Sinai Hospital, New York*

CONNECTICUT TRUDEAU SOCIETY

3:30 Room 119

President: Paul S. Phelps, *Hartford*Secretary: Reginald C. Edson, *Newington*

3:30 THE USE OF ACTH AND CORTISONE IN THE TREATMENT OF PULMONARY DISEASE

Maurice S. Segal, *Boston*; *Clinical Professor of Medicine, Tufts College Medical School; Director of Lung Station, Tufts-Boston City Hospital*

4:00 SURGICAL DIAGNOSTIC PROCEDURES IN PULMONARY DISEASE

Edward A. Gaensler, *Captain MC-USAF*; *Chief, Thoracic Surgery Section, Sampson Air Force Base, Geneva, New York*

4:30 THE CAUSE AND MANAGEMENT OF HEMOPTYSIS

Nicholas D. D'Esopo, *West Haven*; *Chief, Tuberculosis Service, Veterans Administration Hospital*

HEZEKIAH BEARDSLEY PEDIATRIC CLUB

President: Louis Spekter, *Hartford*Secretary: Frank E. Roth, *Hartford*

1:30 LUNCHEON MEETING—Housatonic Lodge, 835 Barnum Avenue Cut-Off, Stratford

Wednesday, April 27

CONNECTICUT ALLERGY SOCIETY

3:30 Room 222

President: E. Russell Webber, *Waterbury*

Secretary: John F. Beakey, *Hartford*

SYSTEMIC MANIFESTATIONS OF HYPERSENSITIVITY—VASCULAR ALLERGIES AND THE COLLAGEN DISEASES
Robert P. McCombs, *Boston; Director of Pratt Diagnostic Clinic and New England Center Hospital; Professor of Graduate Medicine, Tufts College Medical School*

CONNECTICUT ASSOCIATION OF MEDICAL RECORD LIBRARIANS

10:30 Rooms 131-132

President: Mary A. LeClair, *Rocky Hill*

Secretary: Marjorie Quinn, *Bridgeport*

10:30 PANEL DISCUSSION ON MEDICAL RECORD DEPARTMENT PROBLEMS

Moderator: Florence M. Fitzgerald, C.R.L., *Chief Medical Record Librarian, New Britain General Hospital*

12:00 Luncheon—Housatonic Lodge, 835 Barnum Avenue Cut-Off, Stratford

2:00 WHAT CAUSES CEREBRAL PALSY? RESULTS OF STUDY BASED ON RECORDS FROM CONNECTICUT HOSPITALS

Russell V. Fuldner, *New Haven; Attending Surgeon, Newington Home and Hospital for Crippled Children; Assistant Clinical Professor of Orthopedic Surgery, Yale University*

3:00 Business Meeting

CONNECTICUT BRANCH OF AMERICAN ASSOCIATION OF MEDICAL SOCIAL WORKERS

3:30 Rooms 205-207

Chairman: Mrs. Victoria Shannon, *New Haven*

Secretary: Miss Josephine Verrengia, *Hartford*

REHABILITATION OF THE HEMIPLEGIC—IS IT WORTH THE EFFORT?

Moderator: Norton G. Chaucer, *Deputy Health Director, Hartford*

Panel:

John C. Allen, *Director, Department of Physical Medicine, Hartford Hospital*

Frank R. L. Egloff, *Clinical Assistant in Psychiatry, Hartford Hospital*

Juliette Anderson, *Head Nurse, Male Medical Unit, Hartford Hospital*

Elizabeth Sessoms, *Medical Social Consultant, Medical Section, State Welfare Department*

CONNECTICUT REGIONAL GROUP—MEDICAL LIBRARY ASSOCIATION

3:30 Room 124

President: Mrs. Madeleine A. O'Connell, *Bridgeport*

Secretary: Miss Barbara A. Prince, *West Haven*

SURVEY OF CARDIAC SURGERY

Thomas H. Connell, *Bridgeport; Assistant Attending Surgeon, Bridgeport Hospital*

CONNECTICUT RHEUMATISM ASSOCIATION

3:30 Room 221

President: David S. Greenspun, *Bridgeport*

Secretary: Harold S. Barrett, *Hartford*

DIAGNOSIS AND TREATMENT OF RHEUMATOID ARTHRITIS—NEWER CONCEPTS

Morris Ziff, *New York; Professor of Medicine, New York University College of Medicine*

Wednesday, April 27

Annual Dinner of the Society

STRATFIELD HOTEL, BRIDGEPORT

7:00

PROGRAM

H. M. MARVIN, *presiding*

INTRODUCTION OF NEWLY ELECTED OFFICERS

PRESENTATION OF GUESTS AND DELEGATES FROM STATE MEDICAL SOCIETIES

FIFTY YEAR MEMBERSHIP AWARDS

Harry Coltman Clifton, *West Hartford*

Irwin Granniss, *Northford*

David Russell Lyman, *Wallingford*

GUEST SPEAKER: CGUNTESS MARIA PULASKI—"My Life as a Spy"

MUSIC

Reservation cards for the Annual Dinner will be included with the program of the meeting which will be distributed to all members; wives of members are invited to attend.



A STRATFORD ELM

Thursday, April 28

9:00 REGISTRATION—Exhibit Hall

AUDITORIUM

9:15 MOTION PICTURE FILM—"PNEUMONECTOMY"

CLAIR B. CRAMPTON, *Middletown, presiding*

10:00 INDICATIONS FOR RESECTION OR REMOVAL OF THE OVARY

Clyde L. Randall, *Buffalo, New York; Chief, Department of Obstetrics and Gynecology, Buffalo General Hospital; Professor, Obstetrics and Gynecology, University of Buffalo*

10:35 CLINICAL SIGNIFICANCE OF HEMATURIA

Clarence G. Bandler, *New York; Formerly Professor of Urology and Director of the Department, New York Postgraduate Medical School and Hospital of Columbia University; Consultant in Urology, University Hospital, New York University-Bellevue Medical Center*

11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS

JAMES W. MAJOR, *Willimantic, presiding*

11:40 THE ROLE OF ANESTHESIA IN SURGICAL MORTALITY

Henry K. Beecher, *Boston; Dorr Professor of Research in Anesthesia, Harvard University; Anesthetist-in-Chief, Massachusetts General Hospital*

12:15 RADICAL PELVIC SURGERY

Langdon Parsons, *Boston; Professor, Gynecology, Boston University School of Medicine; Chief of Gynecology, Massachusetts Memorial Hospitals*

1:00 LUNCHEON—Cafeteria of the High School

VISIT TO TECHNICAL EXHIBITS

PROGRAM ARRANGED BY

THE CONNECTICUT SOCIETY OF AMERICAN BOARD OF SURGEONS

President: Louis N. Claiborn, *New Haven*

Secretary: N. William Wawro, *Hartford*

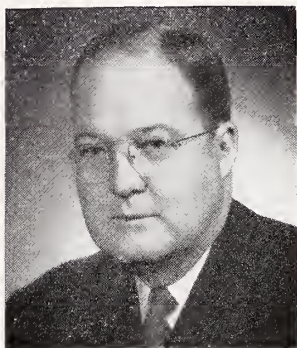
2:00 ABUSES OF ANTIBIOTICS

Chester W. Howe, *Boston; Assistant Professor of Surgery, Boston University School of Medicine; Visiting Surgeon, Massachusetts Memorial Hospitals*

2:45 PROBLEMS POSED IN THE CONTROL OF METASTATIC CANCER BY RADIOACTIVE ISOTOPES

Lee E. Farr, *Upton, New York; Medical Director, Brookhaven National Laboratory; Physician-in-Chief, Brookhaven National Laboratory Hospital*

Speakers — Thursday, April 28



Clyde L. Randall, Buffalo, New York; Chief; Department of Obstetrics and Gynecology, Buffalo General Hospital; Professor of Obstetrics and Gynecology, University of Buffalo.



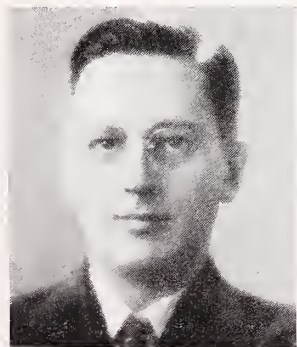
Clarence G. Bandler, New York City; Formerly Professor of Urology and Director of the Department, New York Post-Graduate Medical School and Hospital of Columbia University; Consultant in Urology, University Hospital, New York University, Bellevue Medical Center, New York City.



Henry K. Beecher, Boston, Mass.; Dorr Professor of Research in Anesthesia, Harvard University; Anesthetist in Chief, Massachusetts General Hospital.



Langdon Parsons, Boston, Mass.; Professor of Gynecology, Boston University School of Medicine; Chief of Gynecology, Massachusetts Memorial Hospitals.



Chester W. Howe, Boston, Mass.; Assistant Professor of Surgery, Boston University School of Medicine; Visiting Surgeon, Massachusetts Memorial Hospitals.



Lee E. Farr, Upton, N. Y.; Medical Director, Brookhaven National Laboratory; Physician-in-Chief, Brookhaven National Laboratory Hospital.

Thursday, April 28

MUSIC ROOM

THOMAS J. DANAHER, *Torrington, presiding*

10:00 THE TREATMENT OF THE PAINFUL SHOULDER EXCLUSIVE OF FRACTURES

Paul C. Colonna, *Philadelphia; Professor of Orthopedic Surgery, University of Pennsylvania; Orthopedic Surgeon in Charge of Children's Seashore House for Convalescent Children, Atlantic City*

10:35 THE SPLEEN—FRIEND OR FOE?

Claude-Starr Wright, *Columbus, Ohio; Associate Professor of Medicine, Ohio State University, Attending Physician, Ohio State University Hospital*

11:10 INTERMISSION TO VISIT TECHNICAL EXHIBITS

WALTER WEISSENBORN, *Hartford, presiding*

11:40 MEDICINE AND HOMICIDE

LeMoyne Snyder, *Lansing, Michigan; Medicolegal Counsel; Lecturer in Legal Medicine at Harvard Medical School and in Police Science at Michigan State College; Author of book, "Homicide Investigation"*

12:15 MANAGEMENT OF CERTAIN COMPLICATIONS IN ACUTE HEAD INJURY

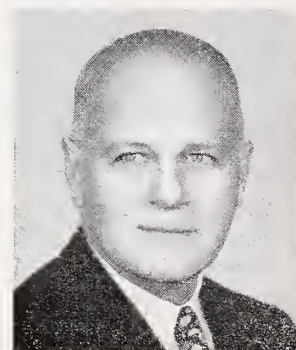
E. S. Gurdjian, *Detroit, Michigan; Professor of Neurological Surgery, Wayne University College of Medicine; Head of Wayne University Neurosurgical Service, Grace Hospital, Detroit*

1:00 LUNCHEON—Cafeteria of the High School

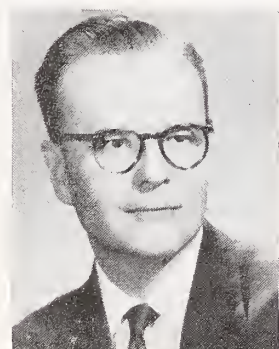
VISIT TO TECHNICAL EXHIBITS



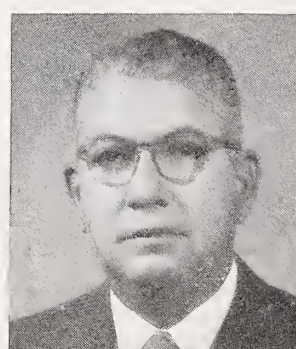
Paul C. Colonna, Philadelphia, Pa.; Professor of Orthopedic Surgery, University of Pennsylvania.



LeMoyne Snyder, Lansing, Michigan; Editorial Staff, *Journal of Criminal Law and Criminology* since 1942; Member of *Argosy Magazine's* Court of Last Resort; Private practice of legal medicine since 1946.



Claude-Starr Wright, Columbus, Ohio; Associate Professor of Medicine, Ohio State University; Attending Physician, Ohio State University Hospital.



E. S. Gurdjian, Professor of Neurological Surgery and Head of Wayne University Neurosurgical Service, Grace Hospital, Detroit, Michigan.

Thursday, April 28

MEETINGS OF SECTIONS OF THE SOCIETY AND GUEST ORGANIZATIONS

EYE, EAR, NOSE AND THROAT SECTION

3:30 Rooms 205-207

Chairman: Sherburne Campbell, *Wallingford*

Secretary: Max Alpert, *Bridgeport*

HEAD AND FACE PAINS WITH SPECIAL REFERENCE TO EENT

Clinical Diagnosis: James C. Fox, Jr., *Hartford*

Pharmacology: Desmond D. Bonnycastle, *New Haven*

Surgical Aspects: Samuel P. W. Black, *New Haven*

JOINT MEETING

3:30 Rooms 120-121

CONNECTICUT SOCIETY OF AMERICAN BOARD OBSTETRICIANS AND
GYNECOLOGISTS

President: Francis X. Fagan, *Hartford*

Secretary: Joseph Klein, *Hartford*

SECTION ON OBSTETRICS AND GYNECOLOGY

President: Clair B. Crampton, *Middletown*

Secretary: Orvan W. Hess, *New Haven*

PANEL DISCUSSION ON TREATMENT OF OVARIAN TUMORS

Moderator: C. Lee Buxton, *New Haven; Professor of Obstetrics and Gynecology, Yale University School of Medicine*

Panel:

Clyde L. Randall, *Buffalo, New York; Chief, Department of Obstetrics and Gynecology, Buffalo General Hospital; Professor of Obstetrics and Gynecology, University of Buffalo*

Langdon Parsons, *Boston; Professor, Gynecology, Boston University School of Medicine; Chief of Gynecology, Massachusetts Memorial Hospitals*

JOINT MEETING

3:30 Rooms 131-132

CONNECTICUT SOCIETY OF PATHOLOGISTS

President: Bernard S. Mann, Jr., *New Haven*

Secretary: Ronald S. Beckett, *Hartford*

CONNECTICUT ASSOCIATION OF MEDICAL EXAMINERS

President: Brae Rafferty, *Willimantic*

Secretary: Samuel B. Rentsch, *Derby*

MEDICOLEGAL INVESTIGATION OF SUSPECTED CRIMES

LeMoyne Snyder, *Lansing, Michigan; Medicolegal Counsel; Lecturer in Legal Medicine at Harvard Medical School and in Police Science at Michigan State College; Author of book, "Homicide Investigation"*

Thursday, April 28

SECTION ON ORTHOPEDICS

MILL RIVER COUNTRY CLUB

Main Street, Stratford

President: Robert G. Reynolds, *Hartford*

Secretary: Russell V. Fuldner, *New Haven*

6:00 Social Hour

6:30 Dinner

USE OF LIVING AUTOGENOUS COSTAL CARTILAGE IN ARTHROPLASTY OF THE HIP JOINT

John J. Flanagan, *South Orange, New Jersey*

SECTION ON PHYSICAL MEDICINE

3:30

Cafeteria

President: Samuel A. Schuyler, *Hartford*

Secretary: H. Bruno Arnold, *New Haven*

ELECTROMYOGRAPHY

Sidney Licht, *West Haven; Chief, Physical Medicine and Rehabilitation Service, Veterans Administration Hospital*

SECTION ON UROLOGY

3:30

Room 127

President: John P. Gens, *Norwalk*

Secretary: Allen M. Margold, *Norwalk*

Program to be announced

CONNECTICUT DIABETES ASSOCIATION

3:30

Room 119

President: Samuel Donner, *Hartford*

Secretary: James C. Hart, *Hartford*

FRUCTOSE IN DIABETIC EMERGENCIES

Henry Dolger, *New York; Physician-in-Charge, Diabetes Clinic, Mount Sinai Hospital*

CONNECTICUT CHAPTER AMERICAN PHYSICAL THERAPY ASSOCIATION

2:00

Room 122

President: Mrs. Anne C. Maes, *New Haven*

Secretary: Miss Arlene Lenner, *New Haven*

2:00 BICEPS CINEPLASTY: MUSCLE PHYSIOLOGY, SURGERY, TRAINING AND FITTING

Charles O. Bechtol, *New Haven; Professor of Orthopedics, Yale Medical School*

3:30 The Physical Therapy Association will join the Section on Physical Medicine in the cafeteria

CONNECTICUT OCCUPATIONAL THERAPY ASSOCIATION

3:30

Room 125

President: Mrs. Alice Rogers, *Middletown*

Secretary: Miss Mary Fiorentino, *Newington*

RECRUITMENT DRIVE IN 1955

Dorothy M. Lehman, *New York; Director of Publicity and Recruitment, American Occupational Therapy Association*

Thursday, April 28

HEALTH SERVICES IN CIVIL DEFENSE

3:30 Music Room

INTRODUCTION

Benjamin B. Whitcomb, *Hartford; Chairman, Committee on Emergency Medical Service, Connecticut State Medical Society*

HEALTH SERVICES IN CIVIL DEFENSE

Edgar B. Prout, *Hartford; Chief of Health Services, State Office of Civil Defense*

AREA MEDICAL SERVICES

Alfred L. Burgdorf, *Hartford; Health Officer, City of Hartford; Hartford Area Medical Director*

ROLE OF HOSPITALS IN CIVIL DEFENSE

Mr. Stuart W. Knox, *New Haven; Executive Director, Connecticut Hospital Association*

THE BLOOD PROGRAM IN CIVIL DEFENSE

Victor G. H. Wallace, *Hartford; Director, Connecticut Regional Blood Bank, American Red Cross*

RADIATION HAZARDS AND RADIATION MONITORING

Lieutenant Leslie W. Williams, *Director of Training, Connecticut State Police Department, Member of the Radiological Committee in State Civil Defense*

PRE-ATTACK DISPERSAL PLAN

Captain William L. Schatzman, *Connecticut State Police Department; Chief of Security, State Office of Civil Defense*

PANEL DISCUSSION

General William Hesketh, *Hartford; Director, State Office of Civil Defense*

Stanley H. Osborn, *Hartford; Commissioner, State Department of Health*

Mr. Arthur Heubner, *Hartford; Industrial Hygiene Engineer, State Department of Health*

Edward H. Kirschbaum, *Waterbury; Medical Examiner, City of Waterbury; Waterbury Area Medical Director*

ART EXHIBIT

CONNECTICUT PHYSICIANS' ART ASSOCIATION

Rooms 219-220

Exhibit Committee

Mrs. Orvan W. Hess, 29 Old Orchard Road, North Haven

John M. Freiheit, 85 Grove Street, Waterbury

The 1955 exhibit of the Connecticut Physicians' Art Association will be held during the Annual Meeting in Rooms 219 and 220 of the Stratford High School. Members of the Woman's Auxiliary to the Society will participate in the exhibit and as a special feature, children of members of the Society have been invited to submit entries.

Technical Exhibits — 1955 Annual Meeting

<i>Space</i>	<i>Firm</i>	<i>Location</i>
1	The Coca-Cola Company	Atlanta, Ga.
2	The American Surgical Supply & Equipment Company	Bridgeport, Conn.
3	Ames Company, Inc.	Elkhart, Ind.
4	E. F. Mahady Company	Boston, Mass.
5	Saratoga Springs Authority	Saratoga Springs, N. Y.
6	Pfizer Laboratories	Brooklyn, N. Y.
7	Brewer & Company, Inc.	Worcester, Mass.
8	Ciba Pharmaceutical Products	Summit, N. J.
9	U. S. Vitamin Corporation	New York, N. Y.
10	Smith, Kline & French Laboratories	Philadelphia, Pa.
11	The Purdue Frederick Company	New York, N. Y.
12	M & R Laboratories	Columbus, Ohio
13	A. S. Aloe Company	St. Louis, Mo.
14-15	Sealy Mattress Company	Waterbury, Conn.
16	Connecticut Hospital Equipment & Supply Company	Hartford, Conn.
17	C. B. Fleet Company, Inc.	Lynchburg, Va.
18	Doho Chemical Corporation	New York, N. Y.
19	R. J. Reynolds Tobacco Company	Winston-Salem, N. C.
20	The Borden Company	New York, N. Y.
21	Wm. P. Poythress & Company, Inc.	Richmond, Va.
22	E. R. Squibb & Sons	New York, N. Y.
23	Desitin Chemical Company	Providence, R. I.
24	Parke, Davis & Company	Detroit, Mich.
25	A. H. Robins Company, Inc.	Richmond, Va.
26	American Ferment Company, Inc.	New York, N. Y.
27	Lederle Laboratories Division, American Cynamid Company	Pearl River, N. Y.
28	Eli Lilly and Company	Indianapolis, Ind.
29	Burroughs Wellcome & Co. (U. S. A.) Inc.	Tuckahoe, N. Y.
30	Pepperidge Farm, Inc.	Norwalk, Conn.
31	The National Drug Company	Philadelphia, Pa.
32	H. J. Heinz Company	Pittsburgh, Pa.
33	Schieffelin & Company	New York, N. Y.
34	The Mitchell Dairy Company	Bridgeport, Conn.
35	Geigy Pharmaceuticals (Division of Geigy Chemical Corp.)	New York, N. Y.
36	Winthrop-Stearns, Inc.	New York, N. Y.
37	VanPelt & Brown, Inc.	Richmond, Va.
38	W. B. Saunders Company	Philadelphia, Pa.
39	E. L. Washburn & Co., Inc.	New Haven, Conn.
40	The G. F. Harvey Company	Saratoga Springs, N. Y.
41	Ives-Cameron Company	Philadelphia, Pa.
42	Maltbie Laboratories Division, Wallace & Tiernan, Inc.	Belleville, N. J.
43	Sandoz Pharmaceuticals	East Hanover, N. J.
44	J. B. Roerig and Company	Chicago, Ill.
45	Abbott Laboratories	North Chicago, Ill.
46	Ayerst Laboratories	New York, N. Y.
47	G. D. Searle & Company	Chicago, Ill.
48	The Stuart Company	Chicago, Ill.
49	The Dietene Company	Minneapolis, Minn.
50	E. Fougera & Company, Inc.	New York, N. Y.
51	Jackson-Mitchell Pharmaceuticals, Inc.	Culver City, Calif.
52-53	Surgeons & Physicians Supply Company	Boston, Mass.
54	The Baker Laboratories, Inc.	Cleveland, Ohio
55	The D. G. Stoughton Company	Hartford, Conn.
56	Schering Corporation	Bloomfield, N. J.
57	Wilfred Pharmaceutical Company	Hamden, Conn.
58	Mead Johnson & Company	Evansville, Ind.
59	Fellows Medical Mfg. Company, Inc.	New York, N. Y.
60	Carroll Dunham Smith Pharmacal Company	New Brunswick, N. J.
61	Warner-Chilcott Laboratories	New York, N. Y.
62-63	The Professional Equipment Company	New Haven, Conn.
Corridor	Connecticut Medical Service	New Haven, Conn.

THE TREATMENT OF ANGINA PECTORIS

By Internal Mammary Artery Implantation Supplemented by Pericardial Fat Wrap

Covering Four Years Clinical and Eight Years Experimental Experience

ARTHUR VINEBURG, M.D., *Montreal, Quebec*

SINCE our first publication in 1946 we have repeatedly reported experimental evidence suggesting that it was possible to graft a third artery into the left ventricle and have it function in coronary artery insufficiency. Since our last report many points have been clarified and the technique of implant has been greatly improved. It is now four years since our first human case of coronary artery insufficiency was operated upon.

A short review of previously published experimental evidence will be given, as well as recent information concerning blood flow studies made on the implanted internal mammary artery. The technique of implantation will be briefly outlined, and our results on the treatment of twenty-nine human cases of coronary artery insufficiency given.

At this juncture let us consider two important questions: First, just how necessary is surgery in the treatment of coronary artery insufficiency?

Second, what experimental evidence is needed before a procedure can justifiably be used on human beings?

A review of published statistics concerning the longevity and disability of patients with coronary artery insufficiency is most enlightening and most definitely disturbing. There is no question that every physician knows of cases that have lived many years with angina pectoris. However, an analysis of the average longevity in a series of cases throws a different light on this question.

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SUMMARY

The clinical results of internal mammary artery implantation in the treatment of coronary artery insufficiency are most encouraging.

About 70 per cent of our patients are greatly improved and have returned to work.

For cases without angina at rest the mortality rate is low—4.3 per cent.

In the experimental animal, the implanted internal mammary artery has been shown to send out large branches in the ventricular myocardium in 71 per cent. These branches are large enough to carry a supply of fresh blood into the heart at a rate as high as 51 cc. per minute.

The pericardial fat pads are used as grafts applied to the surface of the left ventricle to supplement the internal mammary artery revascularization of the left ventricle.

The results on our human patients are beginning to parallel very closely the frequency of mammary-coronary anastomosis demonstrated in our animal experiments.

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In Table I the longevity of patients suffering from angina pectoris is shown for a group of 5,027 cases reported in the recent literature. The average span of life in all cases is well under eight years and as Parker *et al* and Bruck *et al*, who have reported the largest number of cases, point out, is probably five years. The figures quoted refer to angina pectoris, without consideration of the presence or absence of coronary thrombosis with infarction.

In Table II is shown longevity after the first attack of coronary occlusion. The patients quoted by Connor and Holt, and Levine and Rosenbaum, may not have had the benefit of modern cardiological methods of diagnosis. This, however, cannot be said of those quoted by Katz *et al* (see Table III) and

Sigler. Although 81.5 per cent of Sigler's patients (females) and 83.1 per cent (males) were alive at the end of the second year, only 45.3 per cent of the males and 39.8 per cent of the females were alive at the end of the fifth year. These figures have been taken from a rather large source of 1,208 cases very carefully studied, and cannot be minimized. Katz *et al.*, reporting 488 cases with infarction, show a much more serious picture. He reports that 25 per cent of his cases were dead at the end of two months, 50 per cent at the end of one year, and 75 per cent at the end of three years.

In Table III is shown the longevity in a series of cases that have had coronary artery occlusion with infarction.

TABLE I
PROGNOSIS WITH ANGINA PECTORIS

AUTHOR	NUMBER OF PATIENTS WITH ANGINA PECTORIS	AVERAGE LONGEVITY (YEARS)
Herrick & Nazun, 1918 ⁴	200	3.0
MacKenzie, 1923 ⁵	380	5.4 dead group
White, 1926 ⁶	200	3.4 dead group
White <i>et al.</i> , 1931 ⁷	500 followed 23 years: 445 dead— 55 alive	7.9 18.4
Eppinger and Levine, 1934 ⁹	141 fatal cases	4.5 average
Wedd and Smith, 1935 ¹⁰	166 fatal cases	5.8 average
Parker <i>et al.</i> , 1946 ¹¹	3440 Mayo Clinic study	5.0 entire group
Bruck, W. J., Crumpacka, E. L.	5766 patients followed	15 per cent dead end of first year: 9 per cent dead each year thereafter. Avge. 5 year survival 58.4 per cent. Entire group (normal pop. 86.9 per cent). Average 10 years entire series 37.1 per cent (normal pop. 70.4 per cent).
Dry, T. J., and Gage, R. P., ¹¹ 1952	5 to 23 years	

TABLE II
LONGEVITY AFTER FIRST ATTACK OF CORONARY OCCLUSION

AUTHOR	NUMBER PATIENTS	SURVIVED FIRST ATTACK	1ST YEAR	2ND YEAR	5TH YEAR	10TH YEAR
Conner and Holt, 1930 ¹²	287	117	75 per cent well	56 per cent well	21 per cent well	
Levine and Rosenbaum, 1941 ¹⁴	372		75 per cent alive	50 per cent alive	25 per cent alive	
Sigler, L. H. 1951 ¹⁷	1208			81.5 per cent (F) alive 83.1 per cent (M) alive	39.8 (F) alive 45.3 (M) alive	10.4 (F) 10.7 (M)

Note: Average age of onset for Sigler's group—55 years.

TABLE III
PROGNOSIS WITH CORONARY ARTERY OCCLUSION WITH INFARCTION

AUTHOR	NUMBER OF PATIENTS WITH CORONARY THROMBOSIS	MORTALITY
Conner & Holt, 1930 ¹²	287	16.2 dead—first attack
Bedford, 1935 ¹³	31	6 months
Levine & Rosenbaum, 1941 ¹⁴	372 101 fatal cases	3.4 years
Master <i>et al.</i> , 1936 ¹⁵	243 8 per cent dead up to time of discharge	
Katz <i>et al.</i> , 1949 ¹⁶	488 with infarction	25 per cent dead—2 months 50 per cent dead end of 1 year 75 per cent dead end of 3 years
Sigler, L. H. 1949 ¹⁷	1208 423 died after one attack or more 785 alive after one or more attacks	Average longevity 3.8 years (M) Average longevity 3.1 years (F) Average longevity 4.9 years (M) Average longevity 4.5 years (F)
Bruck, W. J. & Crumpacka, E. L. 1952 ^{11a}	1302 cases—previous infarction	5 year survival 45.9 per cent 10 year survival 26.0 per cent
Dry, T. J. & Gage, R. P.	204 cases—subsequent infarction	5 year survival 41.2 per cent 10 year survival 22.7 per cent

Now that we have discussed longevity in percentages, let us consider the ability of those who survive to work. There is no doubt that patients survive coronary artery occlusion with infarction, but what kind of lives do they lead; how many are capable of working and, if they are working, how many of them are symptom free? According to Friedberg¹⁸ about 53 per cent return to work, but of these only 32 per cent are able to work full time. Thus, when we speak of approximately 50 per cent five year survivals after coronary occlusion with infarction, one does not consider how many of these people who survived are useful citizens. In a general study of statistics one is surprised to find that only about 18 per cent of those who survive are able to return to a full and active life.

Now there is no doubt that every physician and every cardiologist knows of patients who have survived 20 or more years following the onset of angina pectoris and who have worked and lived reasonably active lives, and there are many cases reported in the literature. Such cases, however, are the exception rather than the rule, as every general practitioner knows.

It is thus clear that from the most optimistic figures, fewer than 50 per cent of patients with one coronary artery occlusion will be alive at the end of five years, and fewer than one-third of those who survived the first attack are asymptomatic and are capable of gainful occupation. It would seem

from the figures presented that the disease progresses after the first coronary occlusion. Certainly this appears to be true between the first and fifth years after the initial attack (see Table II). Natural forces in the form of collaterals take over after the first coronary occlusion and maintain the myocardial muscle fibres in reasonable condition. Unfortunately the process of coronary artery sclerosis is progressive, so that gradually more and more collaterals are shut off and more and more muscles become fibrotic. Thus, if a new source of blood can be brought to the myocardium before it is destroyed, there is every reason to believe that further myocardial destruction can be stopped.

It must be remembered that the functional unit of the heart is the myocardial fibre. Once this is destroyed it cannot be replaced. When a great number of these fibres are destroyed the reserve of the heart is greatly diminished and eventually a condition is reached where so many myocardial fibres have been destroyed and replaced by fibrous tissue that the most ideal method of revascularization can do nothing to help such a heart. Therefore, it is important to realize that the revascularization of the myocardium should be attempted as soon as possible to prevent progressive destruction and ultimate fatal loss of myocardial fibres. The onset of angina in severe form is, in our opinion, a definite indication for making an attempt at surgical revascularization of the myocardium. This will be discussed later under indications.

EXPERIMENTAL CRITERIA

It has often been said of experimentation that what is true of the animal does not necessarily apply to man and therefore that experimental evidence is of little value. This is partly true. However, what is much more likely to be true is that if a procedure does not work in the heart of a dog or a pig, it is not at all likely to be of value in the heart of a human being. Far too many medical and surgical treatments have been tried out on human beings without having been adequately tested in the laboratory.

Many new drugs have been used in the treatment of angina pectoris which were at first hailed with enthusiasm only to fall into the discard in the light of cold facts. Likewise, numerous surgical procedures have been devised, each to gain a measure of popularity largely dependent upon the personality and energy of the surgeon who developed the procedure, and each, in turn, like other forms of treatment, to be later abandoned. Practically all of these many therapeutic measures were founded on clinical and not upon laboratory data.

There are so many unknown factors in dealing with human coronary artery insufficiency that the value of any clinical method of treatment is most difficult to evaluate. Much time elapses and many lives are lost before the inadequacy of the treatment becomes apparent.

There is little question that before a method of surgical revascularization is attempted on human cases, certain fundamental experimental facts must be ascertained concerning that particular method. In our opinion, the minimal postulates that are necessary to prove the value of extracardiac circulation are five in number. These may be divided into (1) anatomical and (2) functional, of which the latter has four subdivisions—a, b, c, d.

I. ANATOMICAL

Proof must be shown that channels of arteriolar size or larger exist between the coronary circulation and the extracardiac source of blood. These anastomotic channels should be large and numerous enough to be capable of supplying the myocardium with as much blood as is normally supplied by the left coronary artery. These large anastomotic channels must be shown to be present for at least six months and preferably longer. The anatomical proof of the existence of anastomotic channels between the coronary arterioles and an extracardiac source of blood in itself is not sufficient: it is necessary to prove its functional value.

2. FUNCTIONAL VALUE OF AN EXTRACARDIAC BLOOD SOURCE

(a) *Survival following ligation of one of the major coronary vessels.*

Survival of animals following ligation of one or more coronary vessels without infarction gives important functional evidence as to the value of an extracardiac source of blood in replacing an obstructed coronary vessel. This is true provided all occluded arteries are inspected afterwards to make certain that (1) the occlusion is complete, and (2) that there are no branches proximal to the site of occlusion which are open. The latter is particularly true of ligation of the anterior descending branch of the left coronary. Frequently the septal branch arises directly from the left coronary artery. Ligation of the anterior descending branch in such animals cannot be considered complete. It has been our custom, when this occurs, to exclude such animals from both the control and treated series. In this way a much clearer picture is obtained with regard to survival following anterior descending branch ligation.

(b) *Interruption of the extracoronary circulation.*

When animals survive anterior descending branch ligation following a revascularization procedure, it is assumed that the majority survive because of the blood supplied to the myocardium from an extracardiac source. If this is true, then interruption of this extracardiac source of blood should result in immediate death, or survival with a large infarction.

(c) *Flow measurements of extracardiac blood source.*

It is important to be able to measure the amount of blood delivered to the myocardium by an extracardiac blood source. In addition, it should be shown that the blood which flows into the heart is actually used by the functional unit of the heart—the myocardial fibre. To determine whether fresh arterial blood to the heart does not bypass the myocardium but is actually used by the heart muscle, oxygen consumption studies must be made.

(d) *Production and treatment of artificially produced coronary artery insufficiency.*

The production in animals of coronary artery insufficiency and its treatment by the introduction of an extracardiac source of blood is very important. This can be done by wrapping a piece of Dupont PT 300 cellophane around the origin of the anterior descending artery and slowly reducing, over several months, the exercise tolerance of the animal to a very low point. The successful introduc-

tion of an extracardiac source of blood into the ischaemic myocardium should result in a return of the animal's tolerance to exercise as compared with the untreated and incapacitated animals.

Three different types of surgical procedure are now used in the treatment of human angina pectoris; (1) pericardial cardiopexy, (2) arterialization of the coronary sinus, and (3) internal mammary artery implant.

ARTERIALIZATION OF THE INTRAMURAL VESSELS OF THE LEFT VENTRICULAR MUSCLE BY MEANS OF INTERNAL MAMMARY ARTERY IMPLANTATION

Before proceeding to the details of this method for the revascularization of the ventricular muscle, a short review of the histological, anatomical and pathological structure of the myocardium must be given. There are two factors, now generally accepted, upon which the procedure of internal mammary artery implantation is based: one is the anatomical pattern of the myocardial circulation, the other is the modern concept of the pathology of coronary artery sclerosis.

1. ANATOMICAL STRUCTURE OF THE VENTRICULAR MYOCARDIUM

It is well known that there are many differences between cardiac and skeletal muscles. The difference in which we are most interested concerns the peculiarly rich network of blood vessels which supply the myocardial muscle fibres. Actually there exists within the myocardium a veritable spongework of vessels. Their arrangement is graphically shown in Figure 1. As the smaller branches of the coronary arteries subdivide, they leave the surface of the heart and penetrate the myocardium at right angles. As they approach the endocardial surface they

resume their horizontal direction and arborize into a rich arteriolar bed from which the capillaries arise. The arterioles also communicate directly with sinusoid arterial spaces which connect with the myocardial sinusoids. These latter vessels, with a lumen of from 50 to 250 μ in diameter, run a wandering course about the muscle fibres and anastomose with each other and the capillaries. Because of the structure of the myocardium, an implanted internal mammary artery with an open attached intercostal vessel fails to form a surrounding hematoma and remains patent for an indefinite period of time.

The second factor which indicates that internal mammary artery implant will be a successful method of treating coronary artery insufficiency is based on the pathological character and distribution of coronary artery disease.

2. PATHOLOGY OF CORONARY ARTERY DISEASE

The generally accepted idea that coronary artery disease is widely spread throughout the coronary tree has not been borne out by pathological study. Arteriosclerosis of the coronary arteries is usually, if not always, confined to the epicardial part of their courses and never involves the penetrating myocardial branches to any significant degree. Thus, in coronary artery sclerosis there is a vast network of arterioles, etc., deep within the myocardium which are free of disease.^{20,21} If arterial blood is delivered to this network then it can reach all parts of the ventricular myocardium. An implanted internal mammary artery thus can bridge over the blocked superficial coronary vessels so that arterial blood can reach the intact, deep arteriolar system of vessels which are still open and free of disease.

In the evolution of human coronary artery sclerosis a similar process occurs. It has been shown by Zoll²² that in the normal human heart intercoronary anastomoses are rare. However, in the presence of arterial occlusion, intercoronary anastomoses develop distal to the point or points of occlusion. The development of such intercoronary anastomoses occurs frequently and probably prevents myocardial infarction when the occlusion develops slowly. Zoll reports a study on a human heart with occlusion of the left anterior descending, left circumflex, and right coronary vessels of such extent that the major portion of blood supplied to the heart came from a large separate conus artery which was connected with small branches below the points of occlusion in the descending coronary artery.

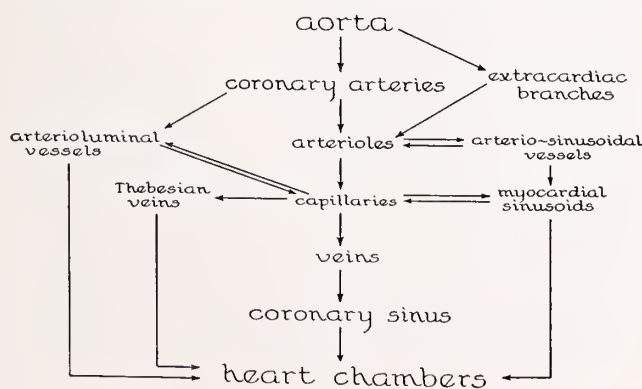


FIGURE 1

Relationship between the various components of the coronary circulation

It is therefore not surprising to find that an implanted internal mammary artery carrying a high pressure and placed beyond the point of coronary artery occlusion and among the deep myocardial vessels into a low pressure area is capable of vascularizing the left ventricular vessels. We feel that the term "collateral circulation" should be reserved for intercoronary anastomoses. Revascularization of the myocardium by collateral circulation can only occur providing one of the major coronary vessels is still patent. In the presence of major disease of the coronary vessels this can only occur through the mechanical development of an extracoronary source of blood. This occurs so rarely under natural conditions that it is useless to await its development. The futility of waiting is borne out by the high mortality rate of coronary disease treated by medical measures only.

The use of the left internal mammary artery as an extracoronary source of blood supply was first attempted by us experimentally in 1945, and five years later, in 1950, we applied the procedure to our first human case of coronary artery insufficiency. The experimental data upon which the implant procedure is based has frequently been published but will be briefly reviewed here.

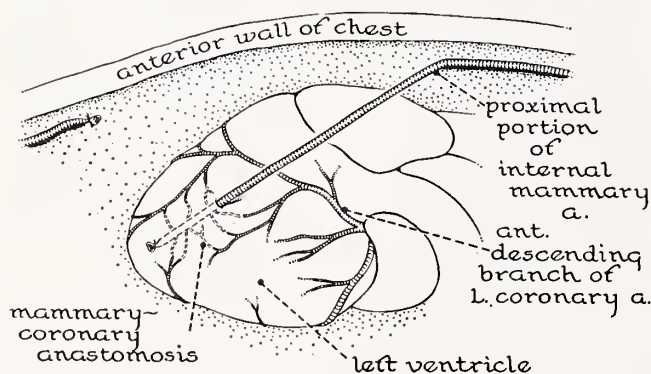


FIGURE 2

Internal mammary artery detached from its chest wall attachment and buried in a tunnel in the left ventricular myocardium. Open stumps of intercostal not shown

ANATOMICAL PROOF OF MAMMARY-CORONARY ANASTOMOSIS

PROCEDURE

The left internal mammary artery is freed from the chest wall from the 4th to the 6th intercostal space. The distal end is doubly ligated and transected between the ligatures. A tunnel is made in the anterior wall of the left ventricle and the freed

portion of the artery is pulled into the tunnel and there fixed. The intercostal vessels which arise from the freed portion of the internal mammary artery are ligated, except for the 6th, which is transected just before the implant is pulled into the myocardial tunnel. The internal mammary artery is thus placed in a tunnel within the ventricular myocardium, with an open, freely bleeding intercostal branch (Figure 2). In another technique, the artery is buried with its end open (Figures 6 and 7).

In previous publications^{23,24,25} it was shown that an anastomosis developed between the implanted internal mammary artery and the left coronary circulation. The presence of such mammary-coronary anastomoses in dogs was proven in the following manner:

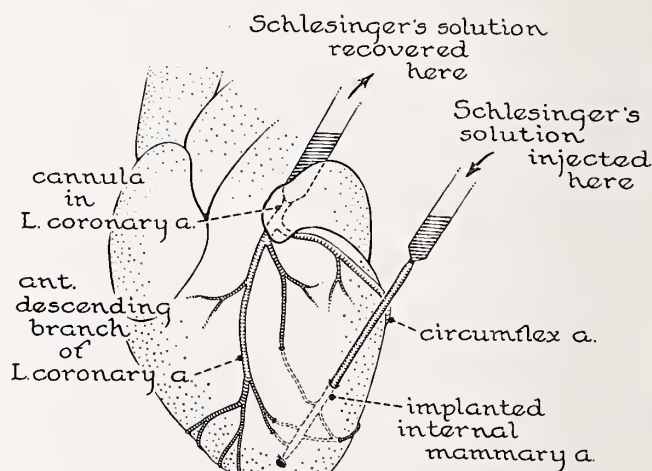


FIGURE 3

How Schlesinger's injection mass is introduced through a cannula placed in the internal mammary artery weeks to months after implantation. In the presence of coronary-mammary anastomosis, the injection mass spreads throughout the left coronary arterial network and emerges from a second cannula placed in the mouth of the left coronary artery

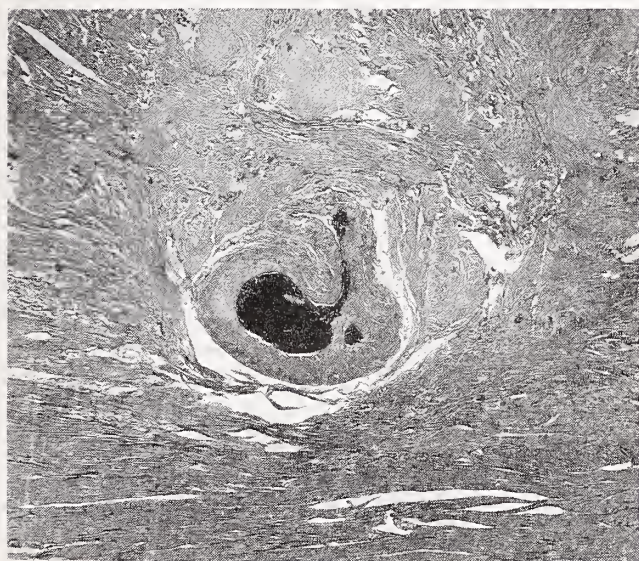
Weeks or months after implantation, the animals were sacrificed. Two separate cannulas were used: one was inserted into the internal mammary artery facing towards the heart, the other was tied in the mouth of the left coronary artery. The heart and attached internal mammary artery were removed from the thoracic cavity, and Schlesinger's injection mass was introduced through the internal mammary artery. This injection mass is known to pass freely through no vessel smaller than an arteriole 40 microns in diameter. Where there was a large anastomosis the injection mass was seen to enter the internal mammary artery, spread throughout the coronary arteries

of the left ventricle, and fill the cannula placed in the mouth of the left coronary artery (Figure 3). This would indicate that the anastomosis is with the arterial rather than the venous side of the coronary circulation. Afterwards, injection x-rays were taken to show the distribution of the injection mass throughout the coronary circulation.

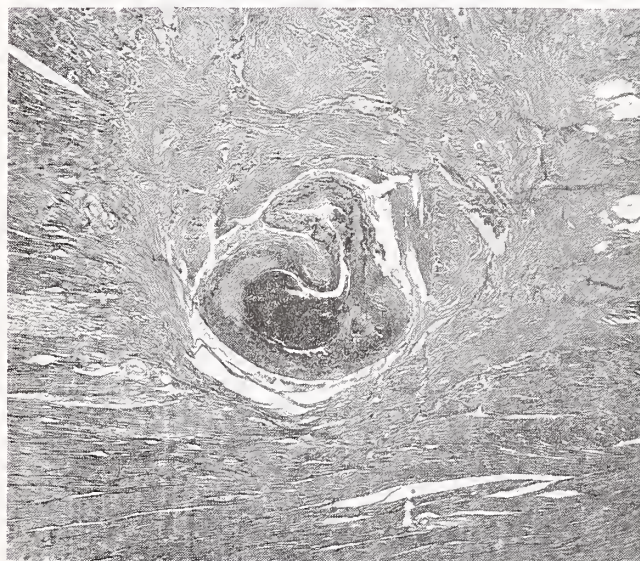
Following x-ray studies, sections were taken through the area of implantation and serial section studies were made. These serial sections showed branches leaving the implanted internal mammary artery, and these branches could be followed out

into the myocardium. In Figure 4, serial sections are shown which have been taken through the site of internal mammary artery implantation 62 days after implant. Note how the injection mass in the lumen of the implanted internal mammary artery can be followed out through a new branch into the myocardium.

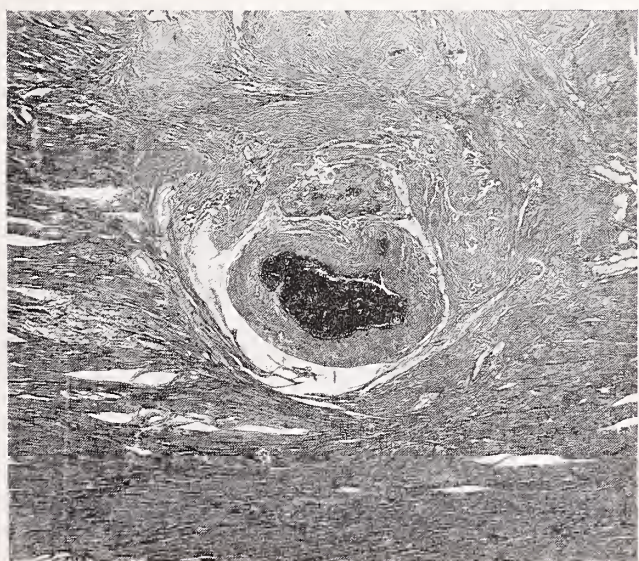
Having proven the presence of mammary-coronary anastomosis by injection, by radiographic studies, and by serial section, it was then decided to attempt visualization of the anastomosis by plastic casts.



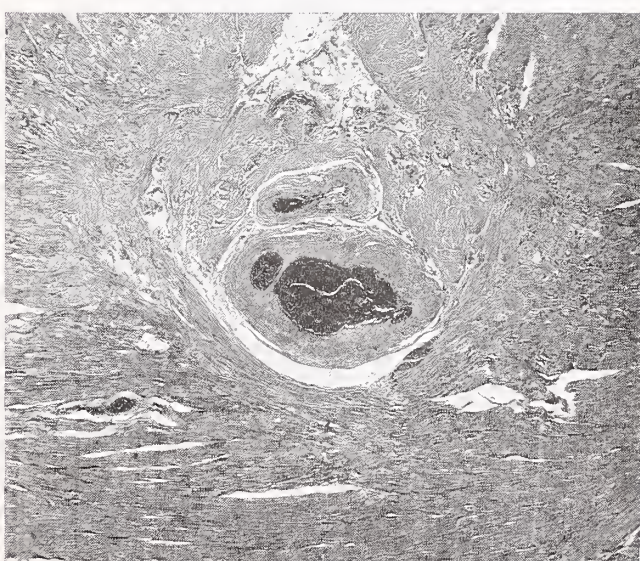
A



B



C



D

FIGURE 4

Serial section through site of internal mammary artery implant 62 days after implantation, showing branches of transplant, with injection in lumen

From a few days to many months after implantation, a plastic solution was injected into the proximal end of the internal mammary artery. At the same time, similar plastic solutions of different colors were introduced into the left coronary artery and the coronary veins. The injection mass did not enter the capillary vessels. Acid and alkaline solutions were used for digestion and the resulting casts were studied under the dissecting microscope.

Two types of implants were studied: one in which the internal mammary artery was buried within the myocardium with its end open, and the other with it closed but with an attached open, bleeding intercostal branch. When the internal mammary artery is buried with its end open and bleeding into a myocardial tunnel, an anastomosis occurs between it and the left coronary arterioles within five days. The entire left coronary arteriolar system can be filled with plastic substance through this implanted artery (Figures 5 and 6). Such

anastomoses have been found to be present at least two and one-half months after implantation (Figure 7).

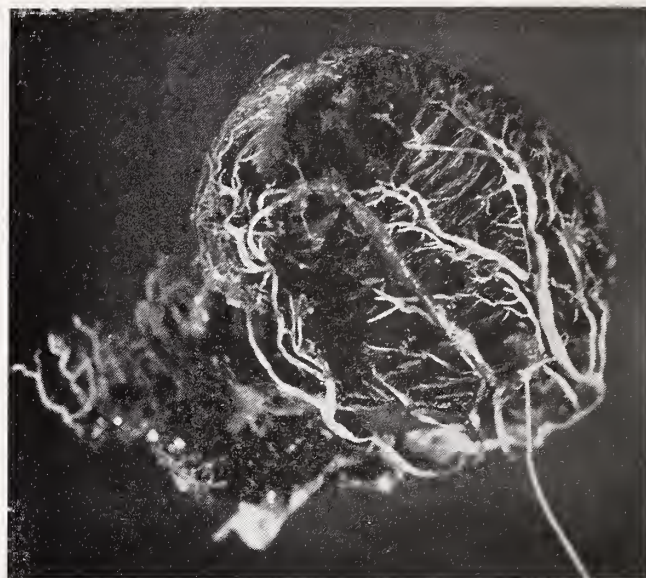


FIGURE 6

Same cast as Figure 5, except that the coronary vessels superficial to the implanted internal mammary artery were removed to show underlying internal mammary artery. Note how in five days vessels leave the implanted internal mammary artery to join the left coronary arteries

When the internal mammary artery is buried with its end closed, but with an open 6th intercostal artery, i.e., the standard implant frequently during the past eight years, then the artery can be seen to branch at the end of 12 days (Figure 8).

These branches grow and at the end of three to four weeks are well formed arterioles which join up with arterioles lying in the left ventricular myocardium. The anastomoses between the new branches from the internal mammary artery and the arterioles of the left coronary artery are, however, not usually fully developed under six weeks to two months.

In some of our injected specimens the casts show that the new branches join, not only with the coronary arterioles, but occasionally with the coronary veins (Figure 7).

FUNCTIONAL VALUE OF MAMMARY-CORONARY ANASTOMOSIS

Histo-anatomical proof of anastomotic channels between extracardiac arterial sources and the coronary circulation gives no indication of its functional



FIGURE 5

Internal mammary artery (arrow) freed from subclavian to 6th intercostal artery and open end implanted in 2" tunnel in left ventricular myocardium. Dog killed five days later in fight. Vinylite plastic injected through internal mammary artery is seen to fill arterial vessels of left ventricle

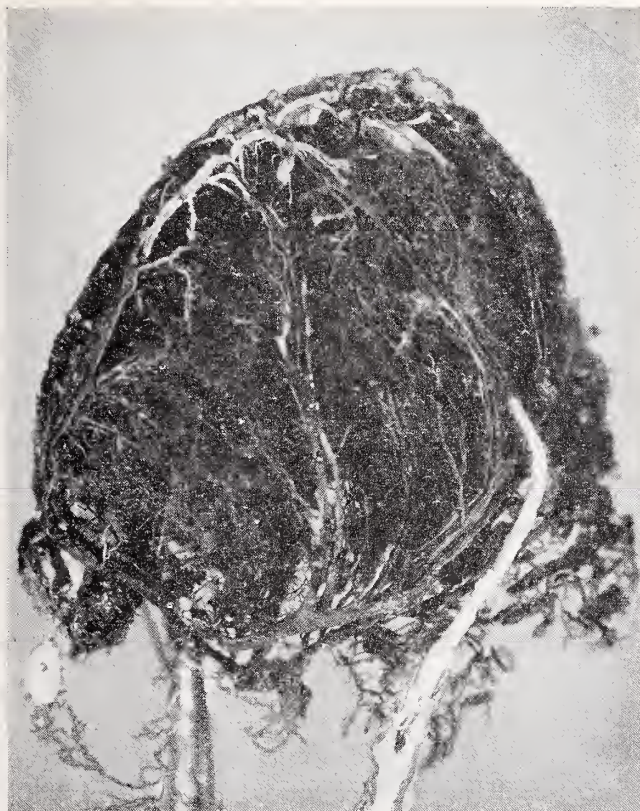


FIGURE 7

Internal mammary artery freed from chest wall from 6th intercostal artery to subclavian and open distal end buried in 2" tunnel in myocardium of left ventricle: partial ligation of origin anterior descending done simultaneously. Chest opened 77 days after operation and subclavian artery isolated and injected with India ink. The ink was seen to flow down the internal mammary artery into the heart, where it was seen in the coronary vessels. Note vast mammary-coronary artery anastomosis, also mammary-venous anastomosis (made by subsequently injecting plastic material into the internal mammary artery)

value. This is true not only of coronary-mammary anastomosis but of all other procedures used for augmenting myocardial circulation. Functional tests give the best indication of the value of the new arterial blood supply. These may be divided into four groups:

- A. Survival experiments following ligation of the anterior descending branch of the left coronary artery.
- B. Removal of extracoronary circulation.
- C. Experimental production and treatment of coronary artery insufficiency.
- D. Blood flow measurements of the internal mammary artery after implantation.

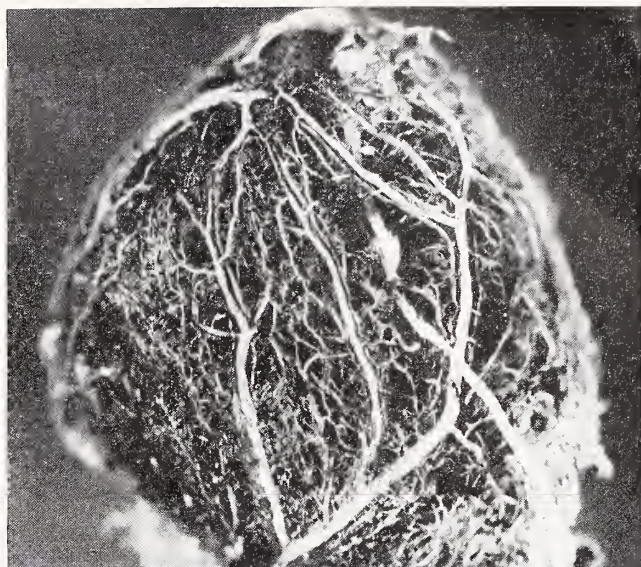


FIGURE 8

Internal mammary artery freed from chest wall between 4th and 6th intercostals and placed in 1" long tunnel in the ventricular myocardium with open stump of 6th intercostal. This animal died of pneumonia 12 days later. Cast made by injecting internal mammary artery with vinylite plastic, and cut away to show buried internal mammary artery with stump of 6th intercostal (arrow). Note tufting and branching from open stump of 6th intercostal attached to internal mammary artery



FIGURE 9

Section through human heart at site of internal mammary artery implant 62 hours later. Note how the vessel lies open between the myocardial fibres, and the absence of surrounding hematoma. This is remarkable because the artery was pulled into position with an attached open bleeding intercostal vessel. The absence of clot in the lumen of the vessel is likewise to be noted

A. SURVIVAL EXPERIMENTS FOLLOWING LIGATION OF THE ANTERIOR DESCENDING BRANCH OF THE LEFT CORONARY ARTERY

There is some divergence of opinion in the literature as to the effects of ligation of the anterior descending branch of the left coronary artery. Some claim a low mortality for this procedure, and others claim a high mortality. The majority of investigators have found the mortality in dogs to range from 70 to 80 per cent. In our series of 10 control dogs, the average mortality rate from anterior descending branch ligation was 80 per cent. It is our belief that the great variation in mortality reported in the literature following anterior descending branch ligation is dependent upon the site of ligation.

Method of ligation. The anterior descending branch of the left coronary artery should be ligated at its origin. The position of the ligature must be carefully checked by examining the left coronary artery to make certain that the ligature has included all branches, other than the circumflex. Frequently one or two septal branches are missed, and occasionally branches arise from the main trunk of the left coronary artery.

An analysis of the results of anterior descending branch ligation is shown in Table IV. A total of 78 dogs had anterior descending branch ligation. There were 10 control animals, and 39 other animals in which the coronary circulation was not augmented. In this group of animals there was an overall 80 per cent mortality, with a 20 per cent survival with infarction. In 29 animals in which a large mammary-coronary anastomosis had developed there were no deaths and no infarctions following anterior descending branch ligation. Thus, it would seem that coronary-mammary anastomosis not only increases

coronary circulation but gives protection against death and infarction.

The experimental data shown in Table IV indicates that coronary-mammary anastomosis, when it occurs, is of value in protecting against death or infarction. However, because of the difference of opinion concerning the value of survival after descending branch ligation, a second group of functional experiments were performed.

B. REMOVAL OF EXTRACORONARY CIRCULATION

Animals which survived anterior descending branch ligation of the left coronary artery were subjected, four to five weeks later, to complete and sudden occlusion of the implanted internal mammary artery. If the internal mammary artery was maintaining the circulation of the left ventricle, then following ligation either death or infarction should result. This is exactly what happened. In three of the animals with an internal mammary artery implant which had survived anterior descending branch ligation, the internal mammary artery was ligated. One animal died immediately; another animal died within 24 hours and displayed an edematous, cyanotic area of the anterior wall from a large infarct in the same location. Another animal survived, but examination of the sacrificed specimens revealed that mulitple intercoronary anastomoses were present.

In all these animals there was a demonstrable mammary-coronary anastomosis. There can be little doubt that in those animals which died following internal mammary artery ligation, the circulation of the anterior portion of the left ventricle was being maintained by the internal mammary artery implant.

The evidence just presented suggested that the

TABLE IV
EXPERIMENTAL DATA (VINEBERG *et al.*)

	NO. OF DOGS	LIGATION ANTERIOR DESCENDING BRANCH OF THE LEFT CORONARY ARTERY		
		DEATH	SURVIVAL WITH	SURVIVAL
			INFARCTION	WITHOUT INFARCTION
		PER CENT	PER CENT	PER CENT
Control	10	80	20	0
Internal mammary artery implant and/or other experiments but without augmentation of the coronary circulation	39	80	3	17
Internal mammary artery implant with coronary anastomosis	29	—	—	100

Note: Internal mammary artery after implantation forms anastomoses with coronary circulation in from 50 per cent to 75 per cent of animals operated upon

internal mammary artery after implantation into the left ventricular wall is capable of maintaining the left ventricular circulation. These experiments, however, were carried out on the hearts of normal animals. It was therefore necessary to attempt to artificially produce coronary artery insufficiency and to treat it by internal mammary artery implantation. Thus, we set out to experimentally produce and treat coronary artery insufficiency and so establish a third functional test of the value of an internal mammary-coronary anastomosis.

C. EXPERIMENTAL PRODUCTION AND TREATMENT OF CORONARY ARTERY INSUFFICIENCY

In this series of experiments, coronary artery insufficiency was produced in dogs and treated by internal mammary artery implant. The first problem was to find a method of producing coronary artery occlusion which would simulate that which occurs in human coronary sclerosis. The second problem concerned the evaluation of coronary insufficiency when it was produced, and its response to treatment.

Method of producing coronary artery insufficiency. The anterior descending branch of the left coronary artery was exposed at its origin. Beneath the left auriculo-ventricular sulcus to the left of the pulmonary trunk, the epicardium overlying the vessel was incised and the bifurcation of the main coronary artery exposed. A doubly folded strip of cellophane (DuPont-P.T. 300), sterilized for 24 hours in a saturated solution of mercury oxycyanide, was twice wrapped completely, but loosely, around the origin of the anterior descending branch of the left coronary artery and fixed in position. Thus a segment of artery from 4 to 8 mm. long was completely surrounded with cellophane.

The cellophane initiated a fibroblastic reaction, with collagen deposition about the artery. As subsequent contracture of the new fibrous tissue occurred, the lumen of the anterior descending branch of the left coronary artery was slowly narrowed. Gradually, that portion of the myocardium nourished by this vessel became ischaemic.

At the end of the experiment when the animals were sacrificed, the anterior descending branch of the left coronary artery was probed to determine the extent of the narrowing. Sections were made through the artery at the site of the cellophane wrap, and careful histological studies made of the degree of coronary occlusion.

Method of evaluation of experimentally produced coronary insufficiency and its treatment:

Exercise tolerance test. In human coronary artery insufficiency there are two outstanding symptoms, namely, substernal pain, and intolerance to exercise. In the dog it is most difficult to detect the presence of pain. It is, however, not difficult to determine accurately the animal's tolerance or intolerance to exercise.

Clinical and pathological experience have associated progressive exercise intolerance with progressive myocardial ischaemia. Thus, in the experimental animal, progressive diminution of exercise tolerance has been accepted as evidence of myocardial ischaemia. In this series of experiments myocardial ischaemia was produced by a cellophane wrap placed around the origin of the anterior descending branch of the left coronary artery. Exercise tolerance studies were carried out before and after cellophane wrap. Later, after internal mammary artery implant, they were repeated in order to establish whether improvement had occurred.

A treadmill was used to exercise the animals. This was made originally for man and was thus very satisfactory for exercising large animals. The exercise tolerance of each animal was established prior to wrapping the anterior descending branch with sclerosing type cellophane. Two groups of animals were studied. The first group was composed of those animals in which coronary artery insufficiency was produced by cellophane occlusion of the anterior descending branch, and treated by internal mammary artery implant. In this series the average running time was reduced from 9 to 12 minutes to 2.5 to 4 minutes, at eight and one-half miles per hour, three months after cellophane wrap. These animals were given an internal mammary artery implant and, three to five months later the running time had returned to six to eight minutes, respectively, whereas the control animals had an average running time of 1.6 minutes at eight and one-half miles per hour. In those animals with an implant in which the running time had returned, there was a wide open coronary-mammary anastomosis.

In the second group of animals, an internal mammary artery implant was performed at the same time as the cellophane wrap around the anterior descending branch. Where there was a widely patent mammary-coronary anastomosis there was no appreciable reduction in exercise tolerance.

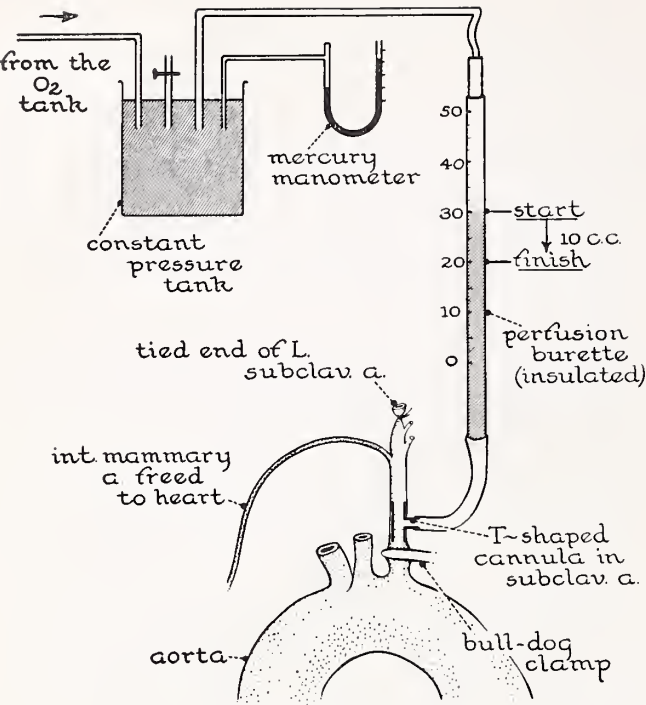


FIGURE 10

A diagrammatic representation of the perfusion apparatus for the measurement of blood flow through the implanted internal mammary artery. The rate of blood flow per minute is determined by clocking, with a stop watch, the time taken for 10 cc. to flow through the internal mammary artery. Flow rates at pressures equal to, above, and below the carotid pressure were studied

D. BLOOD FLOW MEASUREMENTS OF THE INTERNAL
MAMMARY ARTERY AFTER IMPLANTATION

Measurement of the amount of blood delivered to the heart by an implanted internal mammary artery, five, six and seven months after implantation have been made by means of a graduated biochemical burette, a stop watch, and a pressure tank (Figure 10). The left subclavian and internal mammary arteries are isolated, the latter down to its point of entry into the heart, and a cannula placed in the subclavian artery. The outlet of the burette is connected with the cannula in the subclavian artery and the top of the burette to a pressure tank. The time taken for 10 cc. of blood to flow into the heart through the internal mammary artery was measured by a stop watch as expressed in cc.'s of flow per minute. The flow rate has been studied at perfusion pressures above, below, and equal to the carotid blood pressure.

The internal mammary artery is capable of delivering 85 cc. of blood per minute (Table V), with both its end and the sixth intercostal artery open. When the distal end of the internal mammary artery is tied and only the sixth intercostal is open, as it is when it is pulled into the myocardium, the perfusion rate is 45 cc. per minute.

In four dogs studied five to seven months after implantation, and four to six months after ligation

TABLE V
BLOOD FLOW STUDIES
INTERNAL MAMMARY ARTERY IMPLANTATION FOLLOWED BY LIGATION OF
ANTERIOR DESCENDING BRANCH SIX WEEKS LATER

ANIMAL NO.	CONTROL	TIME AFTER IMPLANT	CAROTID B/P MM. HG.	SUBCLAVIAN ARTERY		RETROGRADE FLOW CC. PER MIN	ANASTOMOSIS
				PERFUSION PRESSURE MM. HG.	FLOW CC. PER MIN		
1	I. M. Artery open end + open 6th Intercostal 6th Intercostal only		60 60	60 60	85 cc. 45 cc.		
128		7 months	0	120	11 cc.	Heart started to beat	Large
521		6 months	100 100 50 65	131 231 131 0	3 cc. 14 cc. 5 cc.	Slow retrograde	Small branches
15		5 months	100 75 65	137 77 0	7 cc. 3 cc.	1.3 cc.	Large
33W		5 months	102 96 88	123 93 23	29 cc. 21 cc.	1 cc.	Large

TABLE VI
BLOOD FLOW THROUGH IMPLANTED INTERNAL MAMMARY ARTERY
5 MONTHS AFTER IMPLANTATION
4 MONTHS AFTER LIGATION ANTERIOR DESCENDING BRANCH

CAROTID	ARTERY	PRESSURE	INTERNAL MAMMARY ARTERY PRESSURE AFTER	FLOW THROUGH IMPLANTED INTERNAL
			CORRECTION FOR HEIGHT OF BLOOD COLUMN IN	MAMMARY ARTERY INTO THE HEART
	MM. HG.		PERFUSION BURETTE	CC/MIN.
	102		123	29
	96		93	21
	92		63	10
	90		33	3
	88		23	minus 1 (reverse flow)
ELEVATION PERFUSION PRESSURE ABOVE CAROTID BLOOD PRESSURE				
	86		123	32
	86		153	43
	82		183	51
Dog. No. 33W				

of the anterior descending branch, the flow rate varied from 3 cc. to 21 cc. when the perfusion pressure was equal to the carotid blood pressure, and from 14 cc. to 51 cc. when the perfusion pressure was higher than the blood pressure. The blood flow through an implanted internal mammary artery into the heart five months after implantation is well shown in Table VI. The rate of 21 cc. per minute when the blood and the perfusion pressures are equal is indeed a functional amount of blood to be delivered to a heart via an implant. By increasing the perfusion pressure in relation to the blood pressure, the amount of blood sent into the heart via the internal mammary artery implant reached 51 cc. per minute.

Oxygen Saturation Studies. After making the measurements just described, the animal was bled to death, the heart stopped, and a cannula was tied in

the coronary sinus. Oxygen saturation measurements were made of the blood perfusing the internal mammary artery and recovered from the coronary sinus (Table VII). Table VII shows these figures and also demonstrates how the oxygen saturation dropped from 98 per cent to 40 per cent after traversing the vessels of the heart. At this point the heart began to beat rhythmically again. It would seem that blood which goes through an implanted internal mammary artery enters the myocardial arteriolar system via mammary-coronary anastomoses and then enters the capillary or myocardial sinusoidal system where it yields its oxygen to the myocardial fibres and is returned in part via the venous and coronary sinus systems. In the experiment shown in Table VII, sufficient oxygen was supplied to the myocardium through a five month old internal mammary artery implant to an arrested heart to make it beat again.

TABLE VII
MYOCARDIAL CONSUMPTION OF OXYGEN FROM BLOOD SUPPLIED THROUGH THE IMPLANTED INTERNAL MAMMARY ARTERY
5 MONTHS AFTER IMPLANTATION

CAROTID PRESSURE	INTERNAL MAMMARY	BLOOD FLOW	CORONARY	OXYGEN SATURATION		REMARKS
MM. HG.	ARTERY PERFUSION	THROUGH	SINUS	INT. MAMM.	CORONARY	
DOG KILLED BY	PRESSURE	INT. MAMMARY	FLOW	BLOOD	SINUS BLOOD	
BLEEDING.		IMPLANT		PER CENT	PER CENT	
HEART IN ARREST	MM. HG.	CC/MIN.	CC/MIN.	SATURATION	SATURATION	
o	123	54	30	98	60	—
o	123	—	—	98	55	—
o	123	—	—	98	55	—
o	123	—	—	98	42	—
o	123	—	—	98	40	Heart started to beat



FIGURE 11

This is a cast of the heart of Dog 33W, flow measurement studies of which are shown in Table VI, and oxygen consumption studies in Table VII. This animal had an internal mammary artery implant 5 months before the cast and flow studies were made, and had survived anterior descending branch ligation $3\frac{1}{2}$ months previously

The character of the mammary-coronary anastomosis five months after implantation and three and one-half months after ligation of the anterior descending branch is shown in Figure 11. Through these branches from 21 cc. to 51 cc. of blood per minute were delivered to the heart (Table VII). Sufficient oxygen was supplied to the myocardial fibres to start the heart beating again after its arrest.

DURATION AND CHARACTER OF CORONARY-MAMMARY ANASTOMOSIS

Glenn²⁶ and his associates have confirmed the development of an anastomosis between an implanted internal mammary artery and the coronary vessels. However, they stated that the new vessels tend to disappear at the end of eight weeks. They further suggested that the new vessels were small and resembled granulation tissue. In our series the average interval from implant to sacrifice was 11 weeks

(Table VIII). One animal was kept for 58 weeks after implantation. The anastomoses at the end of that time not only persisted, but were large enough to protect against death and infarction following ligation of the anterior descending branch.

Not only has it been suggested that a coronary-mammary anastomosis tends to disappear at the end of eight weeks, but it has also been suggested that the anastomosis is capillary in nature. Serial sections of seven implants have been examined. Special preparations of these serial sections have been made to show elastic and muscle tissue. The character of the new branches formed by the internal mammary artery implant has thus been studied. They have been found to be arterial in nature, containing both muscle and elastic tissue in their walls. These new arterial branches have been followed by serial section far out into the myocardium until they disappear.²⁷

FREQUENCY OF MAMMARY-CORONARY ANASTOMOSIS

We have heard the odd whisper that "the internal mammary artery implant is excellent when it works, but that most of the implanted arteries are blocked." In order to satisfy ourselves as well as others, we have reviewed our experimental data concerning the frequency of mammary-coronary anastomoses in a series of 60 animals in which the standard internal mammary artery implant procedure was performed (Table IX).

Assuming that the proper technique is employed, the frequency of coronary-mammary anastomosis appears to be related to the heart's demand for fresh arterial blood. Thus, in 39 animals receiving an internal mammary artery implant in normal hearts, there were 18 (46 per cent) mammary-coronary anastomoses, and only 30 per cent of these protected against death from anterior descending branch ligation (according to our standards). Twenty-six (67 per cent) of the implanted arteries remained open many weeks to months later. When the hearts were made somewhat ischaemic by partial ligation of the anterior descending branch, the anastomotic rate was 54 per cent, and the survival rate from anterior descending branch ligation was 72 per cent. Myocardial ischaemia produced by wrapping cellophane around the origin of the anterior descending branch simultaneously, or followed by internal mammary artery implant, resulted in an 80 per cent to 100 per cent anastomotic rate. The average anastomotic rate in normal hearts was 46 per cent, with 67 per cent open vessels. In

ischaemic hearts the anastomotic rate averaged 71 per cent with 86 per cent open vessels. This could be explained as follows:

The chance of an internal mammary artery implant branching will depend, theoretically, on its being placed in an area where the pressure is somewhat lower than within itself. The greater the differential pressure between the pressure within the implant and the pressure in the heart, the greater is the likelihood of the artery branching. Thus, when it is placed in normal heart muscle the pressure differentials are not as great as when it is placed in an ischaemic heart muscle with a low pressure area. On this basis, the higher frequency of mammary-coronary anastomoses in ischaemic hearts can be explained. It is likewise logical to deduct that patients suffering from coronary insufficiency should have about the same anastomotic rate as that seen in ischaemic animal hearts.

TREATMENT OF HUMAN CORONARY ARTERY INSUFFICIENCY BY INTERNAL MAMMARY ARTERY IMPLANTATION

On the basis of the foregoing anatomical, functional and pathological facts, the internal mammary artery implant procedure has been used in the treatment of human cases of coronary artery insufficiency.

SELECTION OF PATIENTS

The selection of patients for a new procedure is always difficult. We dislike classifications but, in a general way, we have found it convenient to divide our cases of coronary artery insufficiency into four groups:

GROUP 1—MILD OR INTERMITTENT ANGINA

In this group are those patients who experience an occasional attack of anginal pain on exercise, or

TABLE VIII
DURATION OF ANASTOMOSIS

TYPE OF ANASTOMOSIS	NO. OF ANIMALS	PRESENCE OF ANASTOMOSIS AFTER IMPLANT (WEEKS)	VALUE OF ANASTOMOSIS AFTER LIGATION OF ANTERIOR DESCENDING BRANCH OF THE LEFT CORONARY ARTERY
<i>Microscopic Anastomosis</i>	1	5	Protection against death or infarction afforded in three animals only
	1	6	
	1	7	
	2	8	
	2	11	
	2	12	
	2	13	
	1	14	
	—		
	12		
<i>Macroscopic Anastomosis</i>	1	6	No deaths or infarctions occurred
	2	7	
	5	9	
	5	11	
	4	12	
	2	14	In coronary artery sclerosis, caused by cellophane irritation, great improvement in exercise tolerance occurred
	1	17	
	1	18	
	3	19	
	1	21	
	1	31	
	1	41	
	1	46	
	1	58	
	—		
	29		

during an emotional disturbance. They are able to work and are capable of living reasonably normal lives. For this type of patient operation is not advisable; it is better to stop playing golf!

GROUP 2—PROGRESSIVE CORONARY ARTERY INSUFFICIENCY WITHOUT DISABILITY

Evidence of progressive coronary artery insufficiency is an important indication for surgery. Patients in this group may still be working, but there is evidence of progression of their disease. This may be shown in the electrocardiogram, or by an increase in the frequency of anginal attacks and, perhaps, progressive dyspnoea.

GROUP 3—PARTIALLY OR TOTALLY DISABLED, BUT WITHOUT ANGINA AT REST

In this group are hundreds of thousands of people, men and women, who are unable to walk more than 50 to 100 feet, or to do 22 steps on the Master two step test without anginal pain. Many suffer pain at rest but in association with emotion, straining at stool, or a heavy meal. Some have night pain which

awakens them. However, when sitting quietly in a chair, without stimuli, they are free of pain. Such cases have been accepted for surgery, in fact surgery should be encouraged, as it has been shown that less than 50 per cent of such patients are alive at the end of five years. Another coronary artery occlusion may so lower their myocardial reserve as to place them in the hopeless, inoperable group of patients with status anginosus.

GROUP 4—STATUS ANGINOSUS

In this group are patients who experience angina at rest. These patients chew nitroglycerine tablets day and night. One of our patients in this group consumed 180 nitroglycerine tablets in two weeks. This type of patient should not be submitted to cardiac surgery. There is insufficient cardiac muscle left to revascularize. Generally, these patients are living on a pin-point opening in the one artery which is still open. Such a small opening usually cannot supply sufficient blood to the myocardium to keep the patient alive during and after a major thoracic procedure. In addition, such patients gen-

TABLE IX
FREQUENCY OF MAMMARY-CORONARY ANASTOMOSIS
(STANDARD VINEBERG IMPLANT)

	NO. DOGS	ANTERIOR DESCENDING BRANCH LIGATION	SURVIVED	WITHOUT INFARCT	ARTERY OPEN	ANASTOMOSIS
Normal Heart	9 Vineberg	not done	—	—	4+	4
	6 Niloff	6	2	1	2	1
	11 Miller	11	3	7	7	8
	13 Buller	13	5	5	12	5
Total	39	30	10 (30%)	13	26 (67%)	18 (46%)
	11	Partial ligation ant. desc. branch (23 gauge needle)	8 (72.7%)	5 (45.5%)	7 (63.6%)	6 (54.5%)
Ischemic Heart	5	Cellophane wrap ant. desc. branch folowed by Implant 3 to 4 months later	Exercise tolerance greatly reduced before I.M. im- plant. Returned nearly to normal in 2. Further reduced in one (abscess). Not tested in 2 (empyema).		4 (80%)	4 (80%)
	5	Cellophane wrap ant. desc. branch — — — Implant Int. Mammary Artery	2—Exercise tolerance re- duced from 8-2½ minims. 3—Exercise tolerance maintained at preopera- tive levels.		2 (100%)	2 (40%) small
Total	21				3 (100%)	3 (60%) large
					17 (86%)	15 (71%)

erally have very little myocardial muscle left to revascularize.

PREOPERATIVE INVESTIGATION

With each patient we have attempted to exclude all other possible causes for his symptoms. This has been done in spite of a well established diagnosis of coronary artery insufficiency. Thus, a search is made for intervertebral discs, infradiaphragmatic and supradiaphragmatic lesions and, in all cases, a psychiatric screening is done. A careful examination of serial electrocardiograms must be made for evidence of recent activity, as well as repeated sedimentation rates. In a few cases we have postponed operation for from four to six months on evidence of activity.

CONTRA-INDICATIONS

(1) Evidence of left ventricular failure. The history of left ventricular failure during an attack of myocardial infarction, with recovery, is not a contra-indication. However, the presence of left ventricular failure most definitely is a contra-indication. (2) Enlargement of the left ventricle, unless it is due to hypertrophy associated with moderate hypertension. (3) Advanced cases of essential hypertension. (4) Evidence of recent myocardial infarction or of active disease. (5) Status angina.

PREOPERATIVE, OPERATIVE AND POSTOPERATIVE CARE

Having determined that the patient has no contra-indications to surgery, quinidine grs. iii by mouth is given twice on the preoperative day and once on the day of operation. An enema is given early in the afternoon of the preoperative day, as we have found that many patients are disturbed by it and have their sleep interrupted. Sodium luminal is administered, gr. iii, at 10 P. M., 11 P. M., and again at 6 A. M. Sodium luminal does not depress the blood pressure as other barbiturates do. At 7 A. M. on the day of operation, morphine or demerol and 1/100 gr. of atropine are given. It is very important that the anesthetic staff are ready to start immediately the patient arrives in the operating room. These patients are generally apprehensive and may develop a fresh coronary occlusion while awaiting operation. The surgeon must check to make certain that the patient is not suffering substernal pain just before the anesthetic is started. We failed to take notice of this warning signal in our 1st, 6th and 18th patients. The first two patients died within 62 hours after

operation from fresh coronary occlusions; the third developed pulmonary edema after the chest was opened and died 11 hours later.

Upon arrival in the operating room the patient is given oxygen to breathe and, at the same time, a 2 per cent procaine hydrochloride drip is started. Induction is achieved with cyclopropane and anesthesia maintained with ether and oxygen. Once the patient is asleep a cutdown is started in the ankle: this is essential in case of a drop in blood pressure.

BLOOD PRESSURE MAINTENANCE

The maintenance of blood pressure is, we feel, extremely important. Neosynephrine drip is used when necessary and the blood pressure maintained at a constant level throughout the operation. The desired blood pressure level is decided upon before operation and is based on the average blood pressure levels recorded four times daily during the 10 days preceding operation. We have attempted to maintain blood pressure levels at not less than 20 mm. Hg. below average preoperative levels. The coronary blood flow is dependent upon the diastolic blood pressure. Cases of coronary artery insufficiency are not like those patients with other types of heart disease in whom the coronary arterial system is comparatively healthy. Lowering of the diastolic pressure decreases the blood flow through the coronary vessels and lessens the amount of blood supplied to the myocardium. When this occurs in the presence of narrowed, calcified coronary arteries, we believe that coronary thrombosis is favored. In addition, the myocardium which is already suffering from ischaemia receives insufficient blood for the maintenance of life, and the development of left ventricular failure and pulmonary edema are therefore favoured.

FAILURE TO MAINTAIN BLOOD PRESSURE

The blood pressure in some of our cases has fallen with induction and, in others, after the patient is postured on his right side. If the blood pressure cannot be returned to proper levels with a slow neosynephrine drip of 5 cc. in 500 cc. of 5 per cent glucose and water, then the operation is not commenced. This happened in two of our patients, neither of whom were operated upon.

OPERATIVE TECHNIQUE

A paper describing our operative technique in greater detail than is possible in this article is now being prepared.

The patient is placed in the right lateral position, and the fifth or sixth rib removed depending on the location of the apex. Procaine, 6 cc. of 1 per cent in normal saline, is injected into the pericardium. The internal mammary artery is freed from the fourth to the sixth intercostal spaces, inclusively. It is doubly ligated at its distal end and cut between ligatures. The mesial and diaphragmatic fat pads are cut away from the fibrous pericardium and left attached mesially and inferiorly, respectively. The fibrous pericardium is removed over the entire anterior surface of the heart and part of the inferior surface. The heart is inspected for areas of infarction and fibrosis, and the left coronary, anterior descending branch, and circumflex arteries are palpated for disease, which can be felt very readily.

A suture of No. 10 cotton is placed in the heart distal to the area selected for tunneling the myocardium. Proximal to this suture, a small incision is made in the epicardium. A tunnel of $\frac{3}{4}$ " to 1" is made by blunt dissection, using a curved mosquito artery forceps. The cotton attached to the tied end of the proximal end of the severed internal mammary artery is picked up with the mosquito forceps and pulled through the tunnel. The sixth intercostal artery attached to the internal mammary artery is then cut and allowed to bleed freely. The internal mammary artery and bleeding sixth intercostal arteries are pulled into the myocardial tunnel. The end of the internal mammary artery is pulled out of the distal end of the tunnel where it is secured by the first suture placed in the heart.

PERICARDIAL FAT GRAFT AS SUPPLEMENT TO INTERNAL MAMMARY ARTERY IMPLANT

During the past five years we have used various techniques of implantation, hoping to increase the rate of mammary-coronary anastomosis. One of these, first reported by Vineberg and Niloff, 1950,²⁵ was the pericardial fat wrap. At that time we thought the internal mammary artery tended to angulate less when surrounded by the pericardial fat. Subsequent experiments were not confirmatory. Bigelow* revived this idea, and pointed out the necessity of preserving the blood supply of the pericardial fat grafts. Since October, 1953 we have pulled the internal mammary artery through the mesial pericardial fat pad before implantation. In addition we have used the pericardial fat pads as a supplement to the internal mammary artery in revascularizing the

ventricular myocardium (Figure 12) whenever possible. After the artery has been pulled through the mesial pericardial fat pad and implanted, areas of epicardium are removed on the anterolateral surface of the heart. The mesial fat pad is then sutured directly to the exposed myocardial muscle. The inferior diaphragmatic fat pad is likewise sutured to a similar area on the posterior surface of the heart which has been denuded of its epicardium.†

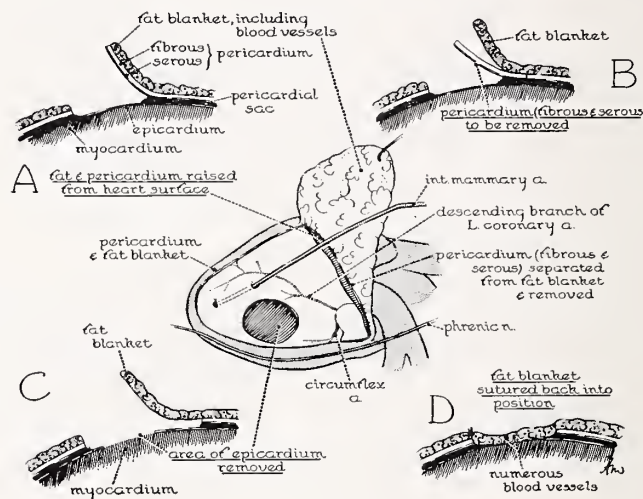


FIGURE 12

(A) Pericardium composed of fat layer on top of a fibrous layer which is lined by parietal endothelium. Epicardium: a thin layer covering the surface of the heart which can be removed, exposing heart muscles. (B) Fat layer separated from fibrous pericardial layer. (C) Removal of fibrous pericardial layer and epicardium. (D) Placement of vascular fat blanket on denuded surface of ventricle. Centre: showing relationship of fat blanket to implanted internal mammary artery

POSTOPERATIVE CARE

The two most important features of postoperative care are the maintenance of blood pressure at a constant level, and the maintenance of fluid and electrolyte balance. Neosynephrine continuous drip is used at 20 to 30 drops per minute depending on the weight of the patient, starting with 5 cc. neosynephrine in 500 cc. of 5 per cent glucose and water. Sometimes this may have to be increased as much as 25 cc. per 500 cc. of 5 per cent glucose and water.

Patients are not moved for 48 hours. A movement of even 15° can cause a definite drop in blood

*Personal communication.

†For details of our first patient, see preliminary report of the first human case operated upon using pericardial fat pads as a supplement to internal mammary artery implant, published in the Canadian Medical Association Journal, 70:76-78, 1954.

pressure. After 48 hours patients can be moved from the back to the right side, never to the left side. The amount of blood pressure instability seems to depend on the extent of myocardial damage present before operation, as indicated by the exercise tolerance. Patients with low exercise tolerance invariably need blood pressure support for two and, sometimes, five

and six days. Others, with exercise tolerance of 20 to 29 steps seem to require very little vasopressor help.

Neosynephrine aerosol is used every two hours as soon as the patient awakens from the anesthetic. Wangensteen suction is started early, as some patients develop abdominal distension. This is dis-

TABLE X
FIRST TEN HUMAN CASES OF CORONARY ARTERY DISEASE
FOLLOWED 1 TO 4 YEARS
No Anginal Pain at Rest

NAME	SEX	AGE	OCCUPATION	TIME		EATING	NIGHT	DYSPNOEA	FATIGUE	PREVIOUS INFARCTION
				D'SABLED (MONTHS)	EXERCISE TOLERANCE					
D. M.	M	54	Oil field worker	7	150 feet	Yes	No	Yes	Yes	None
E. S.	M	49	Executive	24	100 feet	Yes	No	Yes	No	Anterior, posterior
C. A.	M	55	Machinist, welder	24	150 feet	Yes	No	No	No	Large, anterior
A. M.	M	55	Grocer	10	50 feet	Yes	No	Yes	Yes	None
S. E.	M	57	Electrician	10	50 feet	No	No	No	No	Large, anterior
G. A.	M	52	Farmer	28	200 feet	No	No	Yes	Marked	Posterior
L. G. M.	M	39	Physician	24	50 feet	Yes	Yes	Yes	Marked	Anterior, posterior
Status Angina										
J. P.	M	53	Tailor	36	zero	Yes	Yes	No	No	Anterior, posterior
F. C.	M	57	Civil servant	36	100 feet	Yes	Yes	Yes	No	Anterior, posterior
A. C.	M	46	Stevedore	12	150 feet	Yes	Yes	Yes	No	Anterior, posterior

TABLE XI
FIRST TEN HUMAN CASES OF CORONARY ARTERY DISEASE
FOLLOWED 1 TO 4 YEARS
No Anginal Pain at Rest

NAME	TIME SINCE OPERATION (MONTHS)	OCCUPATION	ANGINAL PAIN	EXERCISE TOLERANCE		ABILITY TO WORK	
				BEFORE	AFTER	BEFORE	AFTER
D. M.	41	Oil field worker	None	150 feet	Up to 10 miles	No	8 hours
C. A.	40	Machinist	Following severe exercise only	150 feet	½ mile	No	16 hours
A. M.	34	Grocer	Slight	50 feet	¼ mile	No	Works, and rides horse
G. A.	16	Farmer	None	200 feet	Ploughed 1600 acres	No	Working
L. G. M.	14	Physician	Yes	50 feet	Was 1 mile; influenza and extra-systoles limited	No	No
Status Angina							
3 cases died in first 62 hours post-operatively							
Died Recently							
E. S.*	37	Executive	Yes	100 feet	100 feet or less	No	No
S. E.†	22	Electrician	Occasional	50 feet	½ mile	No	8 hours

Note: *E. S. One failure in group. Died of aplastic anemia—artery blocked.
†S. E. Was returning from work. Pushed car out of snow and died of rupture of old scar interventricular septum.

TABLE XII
SECOND GROUP OF 19 HUMAN CASES OF CORONARY ARTERY DISEASE
FOLLOWED 1 TO 10 MONTHS
No Anginal Pain at Rest

NAME	SEX	AGE	OCCUPATION	TIME	EXERCISE TOLERANCE	EATING	NIGHT	DYSPNOEA	FATIGUE	PREVIOUS INFARCTION
				DISABLED MONTHS						
C. H.	M	45	Engineer	17	11 steps	Yes	Yes	Yes	Yes	Posterior
M. B.	M	36	RR sec. man	18	30 steps	Yes	Yes	Yes	Yes	Ant. septal
W. H.	M	53	Sta. engineer	21	30 steps	No	Yes	Yes	Yes	Posterior
B. P.	M	52	Cook	9	29 steps	Yes	No	No	No	Posterior
P. O.	M	49	Car man	Working 10 nitros	16 steps	No	No	No	No	Posterior
C. H.	M	48	Accountant	Working	16 steps	No	No	Yes	No	Operation not completed
G. T.	M	36	Air pilot	6	20 steps	Yes	No	No	Yes	Posterior
W. B.	M	53	Salesman	Working	49 steps	No	No	No	Yes	Posterior
L. Th.	M	43	Oilman	12	11 steps	Yes	Yes	Yes	Yes	Post. wall
J. H.	M	40	Metal worker	17	16 steps	No	No	Yes	Yes	Large ant.
C. I.	M	53	Tractor reps.	12	15 steps	No	No	Yes	Yes	Ant-post.
R. R.	M	58	Mechanic	3 Sedentary	19 steps No pain	No	No	No	Yes	Posterior
C. T.	M	54	Foreman	17	½ block	No	No	Yes	Yes	Posterior
F. T.	M	59	Merchant	10	1 block	No	No	No	Yes	Posterior
C. S.	M	52	Carpenter	3 years Sedentary	25 steps	Yes	No	No	Yes	Posterior
A. S.	M	55	Salesman	Working	1 block	No	No	No	Yes	None None

Status Angina

T. K.	M	55	Hotelman	2 months	Too sick	Yes	Yes	No	Yes	Vessels sclerosed
C. A.	M	60	Aircraft	6 months	Too sick	Yes	Yes	Yes	Yes	Apical ant. lateral
PAR.	M	31	Vet. amputee	9 months	Too sick	Yes	Yes	Yes	Yes	Posterior

TABLE XIII
RESULTS — SECOND GROUP 19 CASES FOLLOWED 1 TO 10 MONTHS

NAME	TIME SINCE OP. MONTHS	OCCUPATION	ANGINAL PAIN	EXERCISE TOLERANCE		ABILITY TO WORK	
				BEFORE	AFTER	BEFORE	AFTER
C. Hil	11	Engineer	Yes	11 steps	Not tested	No	Not working
M. B.	9	RR sec. man	Occasional	30 steps	Improved ½ mile	No	Part time
W. Hart	6	Sta. engineer	No	30 steps	3-4 miles	No	Working
B. Par	6	Cook	Yes	29 steps	Few blocks	No	No
P. oi	4	Car man	Occasional	16 steps	Improving, has reduced nitros from 10 to 0	Yes	Full day
G. T.	5	Air pilot	No	20 steps	1-2 miles	No	Full day
W. B.	4½	Salesman	No	49 steps	Not known	Yes	Part time
L. Th	4	Oilman	No	11 steps	Not known	No	Part time
J. Han	4	Metal worker	No	14 steps	1 mile	No	Full time
C. Iss	4	Tractor repr.	No	15 steps	Marked improv.	No	Full day
R. Ran	4	Mechanic	No	19 steps	Complication: empyema,	still draining	
C. Tol	4	Foreman	No	½ block	Unknown	No	Working
F. Trev.	2	Merchant	No	1 block	25 yards	Seden.	Working
C. Shep.	1	Carpenter	No	25 steps	Not known	Seden.	Part time

Status Angina

T. Kel	5	Hotelman	?	None	Not known	No	Not known
C. Adams	5	Aircraft	Yes	None	1 mile	No	Working
Par	5	Vet. amputee	Yes	None	50 per cent improved	No	Walking

continued as soon as there are abdominal cramps and passage of gas. Nasal oxygen is used routinely for 24 hours, and longer if necessary. Quinidine sulphate is given by hypo, grs. iii, twice daily. Usually after the third day sodium luminal is substituted for demerol. No hot or cold fluids are given, and the bed pan is never permitted. Mineral oil is started on the third day, as is dicumerol. Usually patients are permitted out of bed on the 16th to 21st day, and can usually leave for home around the fourth postoperative week.

RESULTS

This report deals with our experience with 29 human patients who have undergone the internal mammary artery implant operation. This operation was completed in 28 patients. These cases have been divided into two groups—the first group of 10 patients followed for one to four years, and the second group of 19 patients followed from two to eleven months.

In the first group of 10 cases (Table X), all were disabled from seven to thirty-six months, the average period of disability being 21 months. Half of these patients had had anterior and posterior infarctions, and only two patients showed no evidence of infarction. Exercise tolerance ranged from 50 to 200 feet. In this group, followed one to four years after operation (Table XI), three patients died within 62 hours after operation. All three were cases of status angina. Seven survived the operation. Five, or 71 per cent, have returned to work and are working from 8 to 16 hours daily. One is working 16 hours daily and has slight pain on lifting, or fast walking, three years postoperatively. One worked for two years and then died pushing his car out of the snow. Death was due to rupture of an old myocardial scar. Two still have angina postoperatively. One lived three years and died of aplastic anemia the artery having pulled out of the heart. One is still alive and showing improvement at the end of one year.

In the second group of 19 cases (Table XII) followed one to 10 months, there were only three patients in whom there was no apparent infarction. Two patients had anterior and posterior infarctions. Six were working at sedentary jobs, or with the aid of nitroglycerine. Thirteen were totally disabled from two to 21 months. There were three cases of status angina. Of these 19 patients, the operation was not completed in one, and there was one death

(Table XIII). Seventeen patients underwent internal mammary artery implant and 10 of these had the supplementary procedure of pericardial fat pad graft. Twelve, or 67 per cent, are free of pain, with increased exercise tolerance. Three still have pain but are improved. One has severe pain with no improvement. One has not been followed. Thus, of the 29 patients there were:

Twenty-three patients without angina at rest. In this group there was one death, or a mortality rate of 4.1 per cent.

Of the six patients with status angina, three died in the series, giving a 50 per cent mortality.

The mortality rate for the entire group is 14 per cent.

There were 24 patients who survived, 23 of whom had the implant operation. Fifteen, or 60 per cent, are now completely free of pain. Seventeen, or 73 per cent, have returned to work after operation. Many are working eight to 16 hours daily at hard physical labor.

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HYDROMETROCOLPOS OF THE NEWBORN

A Case Report

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HYDROMETROCOLPOS is one of the rarer congenital malformations encountered in the newborn infant. Because the condition is unusual and at the same time amenable to surgery, we felt that this case report would serve two purposes. First, that it would help those responsible for care of the newborn in considering hydrometrocolpos in their differential diagnosis of an abdominal mass. Second, that it would indicate a method of diagnosis and treatment of this anomaly.

CASE REPORT

A baby girl was born August 4, 1953 after an uneventful full-term gestation. Delivery was by low forceps after episiotomy. The baby cried immediately and spontaneously. No abnormalities were noted and the baby was transferred to the nursery in good condition. Upon arrival in the nursery it was noted that the abdomen was asymmetrical and a mass was felt. The baby became greyish and the respirations were noted to be shallow and irregular. Initial physical examination showed a 7 pound, 4 ounce, white female with moderate respiratory distress and a large firm mass filling the right abdomen and pelvis. The superior aspect of the mass was at the xyphoid. Rectal examination revealed a large firm mass pressing the rectum against the sacral curve. The vagina appeared normal upon separation of the labia. The baby passed two meconium stools and passed urine during the first day of life. Oral feedings of glucose and water were begun 12 hours after birth and were taken slowly with occasional vomiting.

A G.I. series was done the second day and revealed a "large mass in the right side of the abdomen displacing the bowel to the left of the midline." A surgical consultation on the second day was requested and the findings were unchanged from the initial examination. Because the baby was in good condition, laparotomy was decided upon with a preoperative impression of teratoma, neuroblastoma, mes-

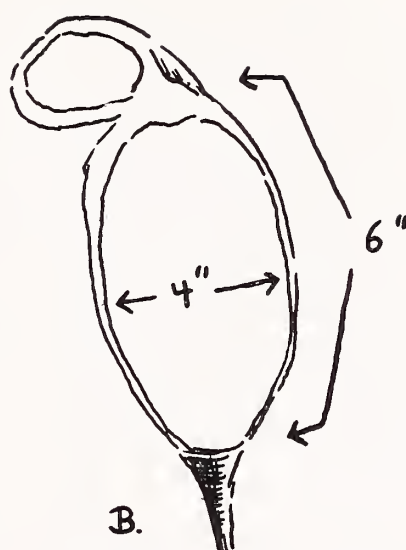
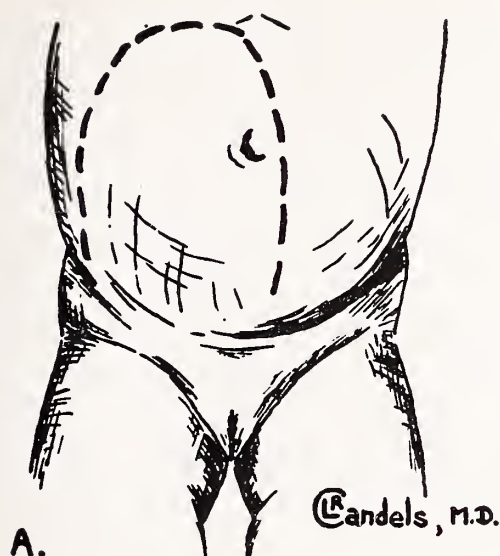
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SUMMARY

A case of hydrometrocolpos is presented. A brief description of the clinical features, pathology, diagnosis and treatment is given.

enteric cyst or renal tumor. On the third day of life a laparotomy was performed under open-drop ether anesthesia. After catheterization of the urinary bladder, during which no abnormalities were noted in the vagina, the abdomen was opened through a right rectus muscle-splitting incision. It immediately became apparent that we were dealing with a hydrometrocolpos and the mass represented an enormously distended proximal vagina measuring 6 inches by 4 inches fusiform in shape. After aspiration of a thin murky yellow fluid, an opening was made through the greatly dilated anterior vaginal wall. The remaining fluid was removed and a finger was inserted and passed up through a dilated cervix into the distended uterine cavity. The proximal one-third of the vagina was occluded by a septum. This occluded portion was pushed below the symphysis until it presented into the lower part of the external vagina and incised with a scalpel so creating an external opening. The incision in the anterior vaginal wall was closed and a small rubber catheter was placed through the external vaginal opening up into the uterine cavity. The abdominal wound was closed and the baby was returned to the nursery in good condition. The surgical exploration took 55 minutes. Postoperatively the baby did very well. Feedings were begun the night of the operative day. The first postoperative day 75 ccs. of whole blood were given. A pinkish drainage



A—Outline above shows extent of palpable mass
B—Lateral diagram showing distended proximal vagina with dilated uterus superiorly

C—Outline indicating actual size of uterus and vagina from a normal baby of this age. (Vagina of 1-2 cm. length and 5-6 mm. width)

spotted the diaper for the first four postoperative days. The catheter was removed two weeks after operation.

The baby began to gain weight and was feeding well. The urine and stools were normal and she was discharged on the 13th postoperative day. Follow-up examinations have revealed no complications. The opening made in the occluding membrane has remained patent and there has been no more draining per vagina. No intra-abdominal mass was palpable two weeks after operation. Growth and development have been entirely normal.

CLINICAL FEATURES

The outstanding clinical features of hydrometrocolpos are a pelvic or lower abdominal mass, varying degrees of urinary and/or rectal obstruction, occasional respiratory embarrassment, and visible or palpable bulging membrane at the hymen or a somewhat higher level in the vagina. Usually the bulging membrane seen upon separation of the labia is the most characteristic finding and should alert the observer to the diagnosis. The abdominal mass may vary in size from that of a walnut to one which almost fills the entire abdomen. The mass is firm, rounded, smooth, and sometimes dumbbell shaped. It can present to either side or be midline in position. At times the mass is considered a distended urinary bladder, and during urethral catheterization the protruding, tense, vaginal membrane is discovered. At this point the alert observer arrives at a correct diagnosis. Rectal examination reveals a firm smooth mass filling the sacral curve. Further physical exam-

ination, birth history, and laboratory tests usually are noncontributory.

ETIOLOGY

The etiology of hydrometrocolpos has been discussed by Mahoney and Chamberlain.¹ The main points stressed by these authors are that the occlusion of the vagina is usually due to an atresia rather than simply an imperforate hymen and that an abnormally abundant secretion of fluid from the uterus is present. In support of the first point they stress the thickness of the membrane and the observation that the membrane protrudes through the vaginal orifice. The second point is supported by the relative frequent occurrence of hematocolpos at puberty after a symptomless infancy, due probably to normal neonatal uterine secretions so small as to cause no vaginal distension until the onset of menses. These authors give evidence that the atresia is probably due to a failure of complete canalization of the vaginal bud, analogous to similar embryological failure producing imperforate anus. The excessive cervical secretions can be accounted for by the estrogenic stimulation received by the fetus via the placental circulation.

PATHOLOGY

Hydrometrocolpos consists of a cystic structure made of up vaginal wall greatly hypertrophied and dilated. The cystic cavity is closed and contains a

thin grey-white or yellowish viscid fluid. The superior wall contains the uterus and ovaries. The uterus is usually enlarged and the cervical canal is frequently patulous. We have found no reports of fluid backing into the Fallopian tubes and thence to the peritoneal cavity. We see no reason why, theoretically at least, this could not occur. The vaginal epithelium within the cyst is flattened and microscopic examination reveals an adult type of epithelium. The cervical glands show increased activity as well as increased secretory activity of the uterine endometrium. The usual microscopic appearance of the vaginal epithelium and endometrium of the newborn for the first two weeks is one of increased secretory activity. This adult microscopic appearance, therefore, accounts for the secretions within the closed cyst, but cannot be considered pathological. However, as stated before, this increased secretory activity together with an anomalous occlusion of the vagina, are the two clinical factors necessary to produce hydrometrocolpos during the newborn period.

DIAGNOSIS AND TREATMENT

On discovery of an abdominal or pelvis mass in a female newborn, the existence of a hydrometrocolpos should be considered. As with many of the rarer clinical entities, the thought of the condition is paramount as the diagnosis and treatment are not difficult in most cases.

The mass may be of variable size and may present on either side. There may or may not be respiratory, urinary, or bowel embarrassment. The most helpful

observation is that of a bulging membrane seen upon vaginal inspection. Occasionally, as in the case described above, no membrane is seen if the atresia is in the upper third of the vagina and the membrane is too thick to balloon down into the lower part of the normal appearing vagina. Probably an infant vaginal speculum would be useful if hydrometrocolpos were seriously suspected. If the membrane is seen, 20 to 30 ccs. of fluid may be aspirated and replaced with Diodrast for roentgen visualization and verification.

The treatment of choice is incision of the membrane, release of the entrapped fluid, and the making certain that the membrane does not close. This is done after urinary bladder catheterization to avoid injury to that structure. At times cases have been described where the urethra and rectum have been pushed together by the pressure from the hydrometrocolpos to such an extent that incision from below would have been hazardous and the membrane has been approached from within the cystic cavity after laparotomy. Most surgeons stress the point of leaving a catheter in place through the incised membrane to assure drainage and avoid a recurrence of the obstruction.

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EVALUATION OF THE SUICIDAL RISK

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EVERY physician is faced, at one time or another, with the problem of evaluating the suicidal risk in a particular patient. Such statements as "I wish I were dead," "There is nothing to live for," "I'd rather die than suffer prolonged pain," call for astute appraisal of the suicidal threat implied in them. This paper will attempt to state the magnitude of the problem of suicide, to discuss some of the older and newer concepts of suicidal motivation, and to summarize the warning signs of impending suicide.

INCIDENCE

On the average, 16,000 suicides are reported as such in the United States each year, in addition to which nearly 100,000 suicidal attempts occur. In 1947 suicide stood third in the order of frequency of the cause of death by violence in the United States. The highest rate of suicide occurs in the 45-54 year age group.¹

Seventy-seven per cent of the persons who committed suicide in 1945, were not hospitalized at the time. Of the remaining twenty-three per cent, more suicides occurred in general hospitals than in mental hospitals.

HISTORY

The first comprehensive book on suicide was published by Morcelli of Tern in 1876.² In this book Morcelli stated that the fundamental motivation in suicide was egotism or self love; and that unsatisfied passion, fear of the future and cowardice so injured this self love that death seemed preferable to further frustration.

Emil Durkheim approached the problem of suicide in his book, *La Suicide*, (1897)³ from the sociological viewpoint. He speculated that this highly individual and personal phenomenon was best explained on the basis of social structure and its ramifying functions. Durkheim classified suicide into three categories; egoistic suicide, altruistic suicide, and anomic suicide. Egoistic suicide resulted from inadequate integration of the individual into society.

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SUMMARY

The physician, be he general practitioner or specialist, is at times faced with the problem of evaluating the suicidal risk in a particular patient. Various criteria are of value in making such an appraisal.

In this paper the high incidence and prevalence of suicide is considered. Representative theories of suicidal motivation are discussed. Suicidal attempts are classified according to sociological criteria, meaning to the patient, and probability of success. Clues useful in evaluating suicidal risk are enumerated. For this purpose, typical findings in the history, mental and physical examinations are examined in order to provide valid criteria of suicidal predictability.

According to this concept, the greater the forces which threw the individual upon his own resources, the higher the suicidal rate rose. For example, egoistic suicide was believed to occur in cases in which there was only slight integration of the individual into his family. On the other hand, altruistic suicide occurred in cases where the integration of the individual into the group was too great. Suicides in this category were felt to be reactions to some higher commandment involving either religious sacrifice or unthinking political allegiance. Both egoistic and altruistic forms of suicide were considered symptomatic of faulty integration of the man into his society: in the first case, inadequately, but in the second case, overadequately. Anomic suicide followed a lack of regulation of the individual by society. This, Durkheim felt, occurred frequently in modern society.

On the basis of these premises, Durkheim favored a sociological solution to the problem of suicide. He advocated the establishment of collective agen-

cies outside the state, though subject to its action, whose regulative influence would help protect the individual from suicide. He suggested, for example, the reconstitution of corporations on the basis of warmth, loyalty, and mutual respect. People working in such corporations, he postulated, could form relationships between one another and between other such corporations based on strong sentiments of solidarity, and the present cold moral temperature of the usual occupational environment would be raised and the suicide rate would fall.

Freud stated that probably no one could find the mental energy required to kill himself unless in doing so, he was turning against himself a death wish which had actually developed towards someone else. This is particularly true in severe depressions wherein the patient, unable to express hostility outwardly, turns this hostility inward against himself. Karl Menninger noted three important elements: (1) the element of dying, (2) the element of killing, and (3) the element of being killed, to be necessary findings in serious suicidal attempts.⁴ When the wish to die is not present in those who attempt self destruction, the results are often curious failures.

Stungo found that self destruction was often not the main or only purpose of the suicide attempt which had been carried out in a setting which precluded success.⁵ Sometimes the meaning of the attempt could be interpreted as an unconscious appeal to other human beings. The outcome, successful suicide or thwarted suicide, depended on the observer's response to that appeal.

An occasional feature in attempted suicide lies in the nature of its being an ordeal, a trial by fire, the outcome of which is regarded as divine judgment. In conformity with this interpretation, failure of the suicidal attempt is accepted as God's will. Following such an ordeal a modification of the relationship between the patient and his environment often results and further attempts are considered unnecessary.

Hendin felt that there were three main causes for suicide and that these could be used as criteria for classification.⁶ His first group comprised those in which spite or a desire to force love were dominant motives. Hence, reactive depressions and the suicidal attempts associated with lovers' quarrels were included in this group. In addition, patients with character disorders who had minimal suicidal intent

plus a desire to manipulate the environment were included in this group. The second group comprised those who had suffered loss of a loved one. Here were included neurotics who were seeking to establish a new attachment in place of a recently deceased loved one and those elderly passive dependent individuals who had suffered a loss some time previously. The third group comprised those suddenly overwhelmed by feelings of guilt. This group included primarily the schizophrenics who attempted suicide. Hendin's studies dealt primarily with neurotic patients who were suffering from the loss of a loved one. Clinical depression of any great extent was often absent despite a high degree of suicidal intent. For the most part, these patients had problems connected with expressing aggressions that antedated the relationship which was apparently involved in the act. With the termination of this current relationship, however, a diffuse expression of aggression would occur. Then inability to find a satisfactory substitute for this diffuse aggression resulted in its being turned inwards. This very inability to establish a needed relationship seemed to be responsible for self-directed hostility and suicide.

CLASSIFICATION OF PROBABILITY

Suicidal thought and attempts can be classified into a scale of increasing probability. Raines provides such a classification with four main categories:¹

(1) Suicidal thoughts and ideas.

Suicidal thoughts occur to a high percentage of people, both normal and otherwise. Schilder, in a study in 1933, showed that fifty per cent of normals had considered suicide in more than a passing manner at one time or another during their lives. Another study of a group of doctors indicated that nearly eighty per cent had at one time or another considered suicide.

(2) Suicidal preoccupations or ruminations.

Such preoccupations are obsessions which ordinarily appear in a setting which might produce any obsession. When they occur in the presence of severe depressions, they must always be considered a serious warning of possible suicide.

(3) Suicidal gestures.

These are oftentimes difficult to evaluate. As mentioned previously, they may be bids for attention with no suicidal wish, yet at times what might be considered a gesture represents a bona fide attempt

which failed. On the other hand, sometimes the gesture inadvertently succeeds.

- (4) Suicidal attempts.
 - (a) Unsuccessful.
 - (b) Successful.

These two categories are closely related and may fade one into the other.

Some types of suicidal drives do not fall into the above classification. These may be thought of as "unconscious" suicide, "concealed" suicide, or as "physiological" suicide. The latter is perhaps of more importance than is generally realized. Physiological suicide is often overlooked by internists, surgeons, or psychiatrists alike. Diabetics are especially prone to physiological suicide. Whenever a diabetic, previously well balanced on insulin and diet, becomes uncontrollable and repeatedly slips into coma, evaluation to determine the possibility of attempted physiological suicide is necessary. Another common form of physiological suicide is demonstrated by the uncooperative patient who stubbornly refuses to abide by medical or surgical counsel and, as a result, dies.

EVALUATION OF THE RISK

Various clues are of help in weighing the suicidal risk in a particular patient.⁷ Such clues can be sought in the medical history, the psychiatric history, both recent and past, the mental status, and the physical examination of the patient. Ancillary information from relatives may be invaluable.

Any history of recent suicidal attempt must be viewed seriously. It is not at all unusual for depressed patients to repeat the suicidal attempt one or more times if they fail. Up to forty per cent of suicides mention their suicidal intentions. One may never dismiss the possibility of suicidal intent in a patient who talks about it beforehand as a mere attention getting device. Likewise, the finding of a hidden or apparently discarded suicide note should be given considerable weight.

A history of recent depression must be viewed with special caution. Even the patient who appears well out of his depression and in the process of making new plans for the future may still be suicidal. At times a clever patient will openly make such plans to allay concern, in order to kill himself without interference. Groundless depressions were formerly thought to be the main causes of suicide; but now it is generally recognized that loss of employment, financial reverses, disappointment in

love, grief over an ailing child, or threatened exposure of a misdeed, may also result in suicide. Recent heavy or unusual drinking, often associated with prolonged "hangover" blues, should alert the physician, since deeply depressed patients sometimes drink to relieve the discomfort associated with an unrecognized depression. The symptoms of such an unrecognized depression may include unaccustomed difficulties in talking with people, fatigue, restlessness, and apprehension.

Statistics taken from a study at Eastern State Hospital in Washington, show that fifty per cent of the patients committing suicide within the hospital were schizophrenic, predominantly of the paranoid type.⁸ Forty-five per cent of the patients who committed suicide had at no time shown depressive features in their illnesses.

The past history may reveal an old suicide attempt. This makes the danger in the present greater. The factors involved in the previous suicidal attempts should be investigated because they may be of prognostic importance in differentiating the hysterical type of suicidal gesture from the serious one that failed. It is often difficult for the physician to obtain an accurate picture of a past suicidal attempt since the seriousness of the previous attempt may be misrepresented to him. The suicidal patient may minimize his previous attempt in order to reassure the doctor and to forestall preventive measures. Actual amnesia for the past circumstances may occur and fictitious details may be supplied. Members of the family may project their own feelings into the history and thereby either overdramatize it, or minimize it because of feelings of shame and embarrassment.

The means employed in the attempt may attest to its seriousness. Dangerous means such as leaping from high places, shooting in the head or heart region, throwing oneself in front of a truck or a train, or drowning point to serious intent. Ineffectual means suggest a different motivation. Cruel or bizarre means are generally associated with schizophrenia. Multiple means such as poisoning with hanging or sedation with drowning always indicate serious intent. Both the extremely impulsive attempt as well as the meticulously planned attempt point to seriousness of intent.

Zilboorg made the observation that a history of suicide of either parent when the patient was between the ages of four and six or between ten and thirteen is especially meaningful to a depressed

patient.⁹ A history of suicide among the immediate descendants may have minor importance.

The evaluation of the patient's present mental status will provide clues regarding his present propensity to suicide. All agitated depressions point to potential suicide risks. Depressive stupors point to less immediate danger. Close surveillance is nevertheless required. If auditory hallucinations are present the patient may impulsely obey some imaginary command from within to destroy himself. Acute panic states may lead to serious suicidal attempts. Neglected dress and personal hygiene in a patient who is generally neat should alert the physician to a probable depression.

The content of the patient's thoughts may suggest suicidal intentions. Morbid thoughts centering around baseless self accusation and self depreciation must be taken seriously. Likewise, hypochondriacal thoughts in depressed patients need careful evaluation. Patients who have a fear of suicide generally present only a minor risk. Feelings of self pity and revenge, associated with suicidal preoccupations or threats, are suggestive of suicidal risk. The mere presence of transitory suicidal thoughts is not in itself abnormal.

Deferment of direct questioning, because of the danger of putting ideas into the mind of the patient suspected of suicidal intentions, is risky. If there seems to be a possibility of suicide, direct questioning is essential. However, one can not always accept the patient's answers at face value. The most reassuring reply to direct questioning is a qualified denial like, "Yes, I wish I were dead, but I wouldn't lay hands on myself." A plain "No" in an obviously depressed patient has little value. A hedging reply such as "I don't know what to say," or "How much can a person take?" has nothing reassuring about it and is almost as significant as the veiled admission "There seems to be no other way." If direct questioning releases a flood of self accusations or expressions of hopelessness, this response should be viewed as a veiled admission of intent. Likewise, the patient who answers by clapping his head in his hands and moaning or groaning must be considered suicidal. Outbursts of anger and indignation in response to direct questioning cannot always be taken in a reassuring sense. If a patient replies that he has had

suicidal preoccupations recently, but not now, the physician again cannot always be reassured. Generally the patient struggles with his suicidal thoughts over a lengthy period of time. Periods of strong death wishes alternate with periods of relative calm lasting days or weeks. Ignorance of this fact can lead to over optimism with tragic consequences.

The physical examination of the patient may provide further clues. One or more transverse scars on the flexor surface of the wrist are positive proof of a previous suicidal attempt regardless of what the past history reveals. Linear scars about the neck should be viewed with suspicion. Patients who have been suffering from an agitated depression may show patchy loss of scalp hair or show skin injury due to constant rubbing and picking.

Not all suicide attempts are preventable, but most can be anticipated. When the question of suicidal inclination is raised, astute evaluation of the history, mental status, and physical findings will usually answer the question one way or the other. After suicide is prevented, proper treatment of the underlying causes can be initiated, and further attempts prevented.

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ANNUAL COUNTY ASSOCIATION MEETINGS

New Haven, Thursday, March 24

WAVERLY INN, CHESHIRE

Business meeting 4:30 P. M.

Dinner: 7:00 P. M.

Speaker: Vernon Lippard, M.D., Dean of the Yale School of Medicine*Subject:* "THE ROLE OF THE NEW HAVEN COUNTY MEDICAL SOCIETY IN MEDICINE"

Fairfield, Monday, April 4

STRATFIELD HOTEL, BRIDGEPORT

Business meeting 4:30 P. M.

Dinner: 7:00 P. M.

Speaker: Philip D. Stern, member of the lecturing staff of the American Museum, Hayden Planetarium, New York

Subject to be announced

Hartford, Tuesday, April 5

HOTEL STATLER, HARTFORD

Business meeting 4:30 P. M.

Dinner: 7:00 P. M.

Speaker: C. Manton Eddy, Vice-President and Secretary, Connecticut General Life Insurance Company

Subject to be announced

New London, Thursday, April 7

SEASIDE SANATORIUM, WATERFORD

Business meeting 4:30 P. M.

Speaker: George Mitchell, M.D., Professor of Obstetrics and Gynecology at Tufts Medical College, Boston

Subject to be announced

Middlesex, Thursday, April 14

RESTLAND FARMS, NORTHFORD

Business meeting 4:30 P. M.

Dinner: 6:30 P. M.

Speaker and subject to be announced

Tolland, Tuesday, April 19

OLD HOMESTEAD INN, SOMERS

Dinner: 6:30 P. M.

Speaker and subject to be announced

Litchfield, Tuesday, April 19

OLD NEWGATE COON CLUB, NORFOLK

Dinner: 6:00 P. M.

Speaker and subject to be announced

Windham, Thursday, April 21

BEN GROSVENOR INN, POMFRET

Dinner: 6:30 P. M.

Speaker: John Leonard, M.D., Director of Medical Education, Hartford Hospital*Subject:* "THE COLLEGE DISEASES"

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

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EDITORIALS

The Voice of the Turtle

Once again we should turn our eyes toward Stratford and, as in 1951, direct our footsteps to the High School building for the annual meeting of the State Medical Society. The present prosperous town, bordering on the Housatonic River, is a far cry from that settlement of 300 years ago where Goody Bassett was tried and executed for witchcraft. Today the driver of his shiny automobile crosses the river on a bridge for which privilege he passes a ten cent piece through the open window. Before the first bridge was built in 1804 passage across was made possible by the operation of two ferries, one "ye horse boat," the other "to be called ye sciffer."

The early history of medical practice in Stratford portrays many interesting characters. The story of some of these was recounted in the JOURNAL four years ago. Stratford played a prominent place in the formation of the Fairfield County Medical Association. Such names as Curtis, Tomlinson, Shelton, Judson and Goulding served the town faithfully during the past century. These gentlemen would doubtless be amazed if they could attend the 163rd annual meeting of this Society. Not only the physical comforts offered by the spacious school building, but the nature of the program with its emphasis on coronary artery disease, problems of the aged, hormone therapy, and allergies, unheard of in their day, would be impressive.

The last week in April should be a time for mental refurbishing and social replenishing. Connecticut is

fortunate in its compact geographical arrangement; the State Medical Society is likewise fortunate in being able to offer a postgraduate course of two days of such high calibre. Our guest speakers should be confronted by a full house for they give freely of their time and knowledge.

This is Spring and all roads should lead to Stratford.

"For, lo! the winter is past, the rain is over and gone;
The flowers appear on the earth;
The time of the singing of birds is come,
And the voice of the turtle is heard in our land."

Song of Solomon II, 11, 12

The Suicide

Surprisingly enough we are coming to accept more and more the belief that "suicide talkers" should be taken seriously and no longer disregarded. A study of the mortality statistics of suicide in the continental United States shows that this cause of death ranges from ten to thirteenth and in some States west of the Rockies as high as seventh in the list. Oliven* of the Department of Psychiatry at Columbia ventures an "educated guess" that in a typical town of 100,000 people at least 200 to 250 will try to kill themselves each year. Of these, he states, at least 25, and possibly 40, will succeed.

Elsewhere in this issue of the JOURNAL two psychiatrists at the Institute of Living in Hartford discuss one phase of the suicide problem. This should

*"Suicide Prevention as a Public Health Problem," *Amer. J. Pub. Health*, 44:11 (Nov. 1955).

be required reading for every physician, both general practitioner and specialist, since it is not unusual to find general hospitals and practitioners dealing with attempted suicides in an offhand manner, reviving and restoring them and then sending them on their way.

The authors of the article presented to our readers this month do not include a discussion of treatment. This is a psychiatric problem but may be discounted by the fact that many physicians and allied health workers, while aware of a suicidal risk, at the same time lack modern knowledge of necessary procedures and what to avoid with these patients. In addition to these difficulties there is the fact that the type and distribution of facilities for short-term psychiatric care are seriously lacking.

Oliven makes several suggestions for reducing the incidence of suicides. One is the wider use of competently staffed community mental hygiene clinics. Another is the better protection of such public places as high buildings and bridges from which deranged persons have leaped to their death. Illuminating gas might be made so obnoxious to the olfactory organs that no one would think of inhaling it; and finally, the manufacturers of barbiturates for internal use could market only large-sized tablets or capsules which would require larger amounts of water, time and effort to swallow than the tiny, vest-pocket size now in common usage.

Like so many other phases of modern medical practice, the potential suicide is more truly the patient of the internist, the gynecologist, or even the surgeon, and not the psychiatrist, so that the diagnosis must be recognized by the attending physician if proper treatment by the psychiatrist is to be forthcoming. With suicide as with cancer, there is an age group which carries the highest mortality at a time in life when many seem to find adjustment most difficult.

AMA Seal Acceptance Program Replaced

Great credit is due the secretary of the Council on Pharmacy and Chemistry for pursuing to a logical conclusion his conviction that the AMA Councils can be more helpful to the physicians of the United States by replacing the Council seal acceptance program by another more facile and up-to-the-minute procedure. In November, 1953 on invitation the editor of the *CONNECTICUT STATE MEDICAL JOURNAL* appeared before the Council on Pharmacy and Chemistry to plead for a better method of

acquainting the medical profession with information on new drugs, foods and devices as soon as they appeared on the market. Waiting several months or even over a year for the councils to accept or reject a product left much to be desired and exposed the practicing physician to the statements of the detail men from pharmaceutical and other manufacturing concerns as almost the only source of information available. It is greatly to the credit of the Council on Pharmacy and Chemistry in particular that this situation will no longer exist.

Under the new program reports will be issued promptly and frequently on what is new in diagnostic, curative, and preventive medicine. The status of agents and techniques will be reviewed periodically. Basic standards for classes of goods, such as the Council on Physical Medicine and Rehabilitation has done for resuscitators and inhalators, will be developed, and the councils will undertake educational efforts to insure as much as possible the utilization of the information they gather, digest and evaluate.

This all should add up to a real boon to the physician who wants the latest on a new drug from an authoritative source. The real usefulness of a given product should be outlined and questions of toxicity settled before trying out a new drug on a patient. Advertising copy, although not carrying the AMA Seal of Acceptance, will continue to be carefully evaluated and held to certain basic standards before being utilized.

We congratulate the Councils of the American Medical Association with providing this new leadership. We feel confident the physicians of this country will welcome this new means of serving their patients more effectively.

Reflections on "Maintaining a Patient"

Some time ago in these columns attention was drawn to the yearly reports on the costs of hospital care in Great Britain. These are published yearly by Her Majesty's Statistical Office. *The Journal of the British Medical Association* comments editorially in its issue of January 8, 1955 on the 1954 report. It must be remembered that this attempt to analyze hospital costs for the 2,500 hospitals of England and Wales which since 1948 have been under the authority of the Minister of Health.

Over two years ago the Muffield Provincial Hospitals Trust and the King Edward's Hospital Fund for London recommended a system of unit costing

in hospitals and the Minister of Health has sought to devise a plan to introduce such a system. Until this is done it appears that the present returns with these arbitrary adjustments and assumptions will be at best somewhat speculative.

One is not surprised to learn from the statistics that over crowding and understaffing as in mental hospitals can produce extraordinary low costs per week per patient. Teaching hospitals on the other hand have high costs. All this can be deduced by sober reflection and without statistics and we wonder if quality of care as well as kind and quantity may be involved.

When, however, there is a great difference in cost between two London hospitals, each doing undergraduate teaching and each with the same occupancy (£ 3 per week and £ 1 a week for nursing and orderly services), one is led to question if the arbitrary factors introduced into the statistics to adjust the costs of outpatient departments are realistic, and if in fact they do not lead to trying to compare two situations which are not truly comparable. The *Journal* concludes: "The present returns provoke the questions, they cannot provide the answers." Not until unit cost accounting is introduced will the answers be forthcoming.

Connecticut hospitals have responded to the demands of Blue Cross by adopting a uniform system of hospital costing. Unit costing, however, is not yet available: e.g., to meet the situation of chronic wings where long term patients may be charged a rate commensurate with their real costs. A reasonable show of facts will be needed rather than the arbitrary assignment of special rates if the State's auditors are to be satisfied.

One wonders if the suggestions of the Muffield and King Edward's Funds are in any way applicable to our situation, and if any attention is being paid to the British attempts to learn the facts from their 2,500 hospitals now under one command.

Chest Deformities and Cardiac Function

There are a number of chest deformities associated with obvious disease such as the barrel-shaped chest of substantive emphysema or the rachitic rosary. There are others, such as the flat chest,

sometimes described as the "paralytic" thorax, which have, probably erroneously, been linked with specific diseases, in this case pulmonary tuberculosis. Others such as the funnel chest, which is not infrequently associated with the flat chest, have been ascribed to occupational posture: In old works of medicine the funnel chest was described as being unusually prevalent in cobblers, but as the cobbler no longer sticks to his last but does even his repair work largely by machine, and as funnel chests are still common, the association is improbable. The real causes of both flat and funnel chests are still obscure. It is true that such thoracic deformities are usually found in subjects of the so-called asthenic constitution, the slender and often tall individuals who are apt to be introverted and subject to certain types of psychoneurosis.

Apart from purely aesthetic reasons the flat chest and the funnel chest are of interest because it has been claimed that they may give rise to organic heart disease. It is indeed true that in rare instances the lower thoracic and sternal depression of funnel chest may be so pronounced as to cause actual pressure on the heart and to hamper its action, but such cases are extremely rare.

When symptoms suggesting organic heart disease are associated with flat or funnel chests, and this is the exception rather than the rule, they generally simulate those common in neurocirculatory asthenia or effort syndrome: precordial distress or pain, dyspnea, vertigo, general fatigue, and sometimes joint pains and fainting spells. Examination of the heart in such patients may show some displacement to the left and the presence of a loud apical systolic murmur. However, careful study of a group of 25 of these patients by Masters and Stone showed lack of evidence of organic disease, though a few of them showed insignificant electrocardiographic changes or slight prominence of the right border of the heart or of the pulmonary artery. However, the complete historical and clinical findings were against a diagnosis of organic heart disease and most of the patients, evidently suffering from psychoneuroses, promptly improved when reassured that they did not have organic heart disease. All of which is pretty good evidence that chest deformities cause organic heart disease but rarely.

G. B.

THE PRESIDENT'S PAGE

THIS is the last page that I shall have the pleasure of writing as President of the Society. By the time it appears, Dr. Stringfield will have succeeded to that office; his words, not mine, will greet you monthly thereafter.

The year now ending has been filled with rewarding activities and enriched by new friendships that I trust will endure. It has provided an opportunity to learn a little of the pattern of organized medicine in Connecticut and to meet a few of its leaders. It has permitted me to observe, not always with happiness or satisfaction, the kind of activities and meetings conducted by county medical associations. It has brought transient but delightful contacts with related groups such as the Woman's Auxiliary, the State Dental Society, the State Bar Association, and nurses' organizations. A number of committees have graciously invited me to take part in their deliberations, and this has given me a new, gratifying realization of the important part they play in the work of the Society. Quietly and faithfully, wholly unknown to most members, they carry on the vital activities for which the Society exists. They deserve the lasting gratitude of every physician in the State, and I shall assume the happy privilege of acting as spokesman for the profession in extending to each of these faithful, hard-working committees this word of appreciation and heartfelt thanks.

Last December there was an opportunity to speak briefly to the House of Delegates about the Council of the Society, but it would be singularly ungracious of me not to pay my sincere, and necessarily inadequate, tribute to that fine group of men before a larger audience (at least potentially larger!). There are probably few physicians in the State who have any conception of the splendid manner in which the Council members accept and discharge their obligations. During my professional life I have attended many hundreds of committee meetings, some of them constructive and deeply satisfying. But very few have been characterized by such a high level of interest, intelligence, and unselfish devotion as those of our Council. Each member owes loyalty to his county association, and many to a city association also, but when they don the robes of the Council they put aside all selfish and regional influences. Never once in my experience has there been a suggestion that special consideration be given to one county, group, or individual in preference to another. It is always clear that the basis for discussion and judgment is the welfare of the medical profession and of the State Society, not of a particular city or county. Naturally there are differences of opinion, as there must be in any group of twenty or more intelligent people, but these are not based on petty considerations or selfish points of view; they represent the divergent judgments of honest and conscientious men who are striving to act in the way that is best for the cause of medicine in Connecticut.

It is to be hoped that every State Medical Society has a governing body comparable to ours, but it is difficult to believe that any is activated by higher motives or greater devotion to duty than our Council. The Society is blessed in many ways, but in none more richly than in the proud tradition of unselfish service which has become the symbol of the Council and which profoundly influences all who share in its work. It has been a rare and cherished privilege for me to participate in its discussions, and there is joy in the knowledge that I shall continue for another year. To all its members I extend heartfelt congratulations and thanks for their distinguished leadership of a splendid Society, and especially for the inspiring spirit in which they approach its important problems.

Let me end this final page by expressing my deep gratitude to all who have helped to make this year memorable and happy. I am sure that Dr. Stringfield will receive the same warm responsiveness and faithful support that have been extended to me.

H. M. Marvin, M.D.

OUR MEDICAL WORLD

The Scandinavian countries have long been leaders in the development of state-sponsored programs of social welfare. Recent developments in the field of medical practice in several of those countries may be difficult to understand without a background of the history of the relationship between the doctors, the insurance schemes and the state.

Finland

Physicians in Finland were confronted recently by a proposal from a sickness insurance fund, The Friendly Aid Group, that prospective patients be seen first by a nurse trained in social medicine. This screening examination would be for the purpose of finding out which patients supposedly required medical examination and treatment, thereby saving the others the higher cost of a medical fee. To understand how such a proposal could receive serious consideration it is necessary to know that in Finland, as in Sweden, the state controls all medical practice through the sickness insurance funds.

There were in January, 1954, 2,261 registered physicians in Finland. This gives a physician to patient ratio of 1 to 1,825, compared to 1 to 750 in the United States. The two medical schools graduate about 150 students each year. About 35 per cent of the practicing physicians are specialists and slightly over one-half of all of the specialists live in Helsinki.

State insurance for the cost of maternity care began in 1937 and for sickness and old age in 1939. Insurance against occupational accidents is compulsory and is financed solely by the employers. Insurance against the costs of chronic illness is now also compulsory. There is no free choice of physician. Physicians are designated by the insurance funds at their own request, and they receive, as partial payment for their service to patients, a fixed amount, the balance being usually paid for by the patient, but occasionally this is also paid by the fund. Fees are fixed by agreement between the fund and the Medical Association. The physician is assigned to the particular patient in 40 per cent of the cases.

Thus it has come about that the state began by

paying the bill for medical service, then abolished free choice of physician by the patient, and now finally seeks to abrogate the right of the patient even to see a physician, unless a third party decides that it is necessary.

Sweden

Now that government aid to voluntary medical and hospital insurance plans is being recommended by the President of the United States to the Congress, it is interesting to see what has happened in a country where that scheme has been in effect for some years. Although voluntary health insurance had been extended to nearly 70 per cent of Sweden's population with satisfactory results, the government has imposed a compulsory national health insurance program, which began operations on January 1 of this year. The state will support this program by tripling its payments to the insurance funds, making a total contribution of \$150,000,000 a year, which it hopes to raise by increasing liquor taxes. Individuals will still have to contribute (\$36 for a married man earning \$2,000 a year), since the plan will pay only 75 per cent of the physician's fee. The patient may pay the physician the entire fee directly before being refunded by the insurance plan.

Provision is made not only for medical and hospital care (including maternal and infant welfare), but also for disability payments. Some drugs will be free, others discounted, and some must be paid for in full. Free choice of physician will be maintained. King Gustaf is the only one of Sweden's seven million inhabitants who will not be covered by this scheme.

Denmark

Ninety per cent of the Danish people are covered by membership in sick clubs, which are voluntary, but state controlled and subsidized. The other ten per cent are accepted as members of sickness insurance societies, which are also state controlled but not subsidized.

The sick clubs were originated by the working classes in Denmark in the middle of the last century. They were at first frequently sponsored by the

medical profession, which, for philanthropic reasons, gave medical assistance free or for a token salary. Later they entered into private, individual contracts with clubs. These contracts were gradually centralized within the framework of the Danish Medical Association, which was founded in 1857. In 1953 collective contracts covering the entire country were made by negotiations between groups representing both parties.

The first Sick Club Act was enacted in 1892 granting state support. In 1933 the Social Reform Act combined the whole social security organization and health service. Regular members are entitled to free medical care, ambulance service, hospital care, daily allowances, essential medicines, maternity and funeral benefits. Other benefits may include specialists and dental treatment, part expenses in convalescence home, home nursing, massage, orthopedic appliances, spectacles, etc. The state maintains a central diagnostic laboratory in Copenhagen but does not contribute directly to the support of hospitals.

Physicians practicing in rural areas are generally paid fees for service rendered. In city areas they are paid by capitation. Prophylactic medicine is carried out by general practitioners paid directly from public funds. Under this scheme the economic status of the physician has steadily deteriorated. Partnership practice is so new in Denmark, although its popularity is increasing rapidly, that it is still too soon to evaluate what its effect may be on living and working conditions.

Norway

Sickness insurance began in 1911 in this country. It is supported jointly by contributions from the state, the employer, and the insured. It is compulsory for all those over fifteen years of age. All physicians have the right to participate in the scheme but are not compelled to do so. The patient has a free choice of physician. The fees are established by the Norwegian Medical Association and are paid in part from state funds and in part by the patient.

Yale Physicians Discover New Pregnancy Test

An improved test for pregnancy, developed in the research laboratories of the Yale University

School of Medicine, has been reported to be "rapid, economical, and highly accurate." The method is valuable not only as a test for determining pregnancy, but also to indicate whether a pregnant woman is facing a possible miscarriage.

Developers of the improved testing methods are Edward H. G. Hon, instructor in obstetrics and gynecology, and John M. Morris, associate professor of gynecology, at the Yale School of Medicine. Their report was made at the Yale Medical Society meeting elaborating on their paper in the *Yale Journal of Biology and Medicine*.

The test utilizes the common American toad, and the time required to find out whether a woman is pregnant is only four hours, or less. Positive reactions frequently are available in as little as two hours, according to the Yale scientists. They reported that their improved testing methods have been essentially 100 per cent accurate in the diagnosis of normal pregnancy in some 2,000 cases. Heretofore, toad and frog tests for pregnancy have been considerably less accurate. Other pregnancy tests, such as the Friedman test with rabbits and the Aschheim-Zondek (A-Z) with mice are highly accurate, but require from 48 to 96 hours.

All of these pregnancy tests, including the Yale test, are based on detecting a certain hormone, chorionic gonadotrophin, in a urine specimen. The hormone originates in the placenta and will be found in the urine only if the woman is pregnant.

Grants from the U. S. Public Health Service and the James Hudson Brown Memorial Fund of Yale University aided this research project.

Students Admitted to All State-Approved Schools of Nursing in New England During 1953 and 1954

STATE	STUDENTS ADMITTED		NUMBER OF SCHOOLS	
	1953	1954	1953	1954
Maine	289	284	12	9
New Hampshire	274	276	13	13
Vermont	136	117	7	7
Massachusetts	2295	2231	55	55
Rhode Island	205	256	7	7
Connecticut	959	996	21	21
Total	4158	4160	115	112

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PROGRESS IN CLINICAL MEDICINE

USE OF I_{131} IN HYPERTHYROIDISM

Recent Developments as Diagnostic and Therapeutic Aids

SIDNEY C. WERNER, M.D., *New York City*

It is evident that proper treatment depends upon proper diagnosis. On this basis, this presentation, although committed to discuss radioiodine therapy, is introduced by a description of some diagnostic observations made in our laboratory with the isotope.

MECHANISMS OF GRAVES' DISEASE

For the past few years we have been interested in the question of whether Graves' disease is in fact a reflection of hyperpituitarism or is mediated by mechanisms apart from that gland.¹ In the course of these studies it became apparent that the administration of thyroid in large doses did not cause a suppression of I_{131} uptake by the hyperactive thyroid.² When triiodothyronine became available this study was pursued and 2 mg. doses were given, the approximate equivalent of 3 Gms. thyroid daily.³ The patients developed an alarming increase in toxicity but, nevertheless, their I_{131} uptake was not suppressed. This was in contrast to the striking decrease in uptake which occurred in euthyroid control subjects and in patients with nontoxic diffuse goiter. For this reason, and because of other responses to thyrotropin and to iodides,⁴ it was concluded that Graves' disease is mediated by mechanisms apart from the pituitary.

The feature of present interest, however, lies in the failure of hyperthyroid patients to respond to thyroid hormone administration. It is clear that there are diagnostic possibilities implied by these observations, and an investigation of these has led to most gratifying results.⁵ A series of 168 patients with and without thyroid disease was tested. Good separation between the patients with active hyperthyroidism and all the others was achieved. An

The Author. *Chief of Combined Endocrine Clinic and Assistant Attending Physician, Presbyterian Hospital, New York; Associate Professor of Clinical Medicine, Columbia University College of Physicians and Surgeons, New York*

SUMMARY

Several points concerning I_{131} usage in diagnosis and therapy are of more than routine interest. Hyperthyroidism without evident goiter and hyperthyroidism without hypermetabolism occur. There are patients with early eye signs of Graves' disease but who are still euthyroid; the thyroid can be shown to be functionally involved by disease at this time. As a corollary of this work and of another study upon the pathogenesis of Graves' disease, a new and very satisfactory test for hyperthyroidism has become available, which uses tri-iodothyronine and the 24 hour uptake method. The paper concludes with a statement of the eight year experience in the author's clinic with I_{131} therapy in toxic goiter, and briefly summarizes the indications for this form of treatment.

initial 24 hour I_{131} uptake was performed, a daily oral dose of 75-150 micrograms triiodothyronine given for eight days, and then the uptake test repeated. In the patient groups other than toxic goiter, no uptake exceeded 20 per cent following triiodothyronine therapy, whereas no uptake less than 35 per cent was observed in toxic goiter. A few patients with nontoxic nodular goiter failed to respond; the nodules from these patients were subsequently shown to be functionally active by radioautography. Thus triiodothyronine in conjunction with the 24

From the Department of Medicine, Columbia University College of Physicians and Surgeons, and the Presbyterian Hospital in the City of New York

The original work described herein was conducted through the aid of grants from the United States Public Health Service, National Institute of Arthritis and Metabolic Diseases.

Presented at 29th Connecticut Clinical Congress, New Haven, September 15, 1954

hour uptake method provides a simple diagnostic test for hyperthyroidism. Its use is especially indicated in the third of patients tested by the 24 hour uptake method in whom the values fall in zone between 40 and 55 per cent or more in which there is considerable overlap between the values of euthyroidism and hyperthyroidism.

A group of 10 euthyroid patients with the recent onset of the early eye signs of Graves' disease has been identified⁶ because of their lack of response to triiodothyronine. Eight of these patients had an initial I₁₃₁ uptake in the normal range. Interestingly also, the responses to thyrotropin of these patients were those found in active hyperthyroidism rather than those of euthyroid control subjects.

HYPERTHYROIDISM WITHOUT HYPERMETABOLISM

Hyperthyroidism without evident hypermetabolism exists and has been established as an entity through the 24 hour I₁₃₁ uptake method, the serum precipitable iodine (SPI) determination, and the favorable response to treatment.⁸ A group of patients with basal metabolic rate determinations averaging -11 with a range of from $+1$ to -16 were found to have I₁₃₁ uptakes between 38 and 77 per cent, average 55 per cent and SPI values between 9.3 and 25.9 gamma per cent, average 13.1 gamma per cent. Upon treatment, the patients gained weight and became clinically well. The average B.M.R. fell to -6 and the SPI dropped to 7.2 gamma per cent, ranging from 5.6 to 8.9 gamma per cent. This group today can be readily identified before treatment by the administration of triiodothyronine as described above.

Radioiodine has yet another diagnostic use. A rough outline of the gland can be plotted from its radioactivity, by means of a recording device attached to a directional scintillation counter. The counting head is moved mechanically back and forth over the thyroid region and the stylus at a fixed distance follows. As the number of impulses accumulate to a predetermined amount, the recording device is activated and a mark is made on graph paper. Since the recording pen and counting head move the same distance, the denser activity over the gland results in a denser series of dots on the graph paper, as compared to the lighter background count outside the gland. Using this device, it is clear that the thyroid, in some instances at least, of hyperthyroidism without evident goiter is in fact not enlarged but is approximately of normal size⁷ and the normal gland is often not palpable.

ROLE OF RADIOIODINE

So much then for the diagnostic aspects of I₁₃₁ usage and now for a brief review of the role of radioiodine in the treatment of hyperthyroidism. The use of the isotope has been hampered by the uncertainty as to the carcinogenic action of the radiations from the isotope's breakdown within the gland.⁷ Although most authorities deny this likelihood, a denial based on experience cannot yet be made. Most clinics therefore retain a cautious attitude and in our clinic an arbitrary minimal age limit has been established for the therapeutic use of I₁₃₁ in primary hitherto untreated hyperthyroidism.^{7,9} Since surgery is 90 per cent effective, it is believed that patients less than 40-45 years of age with primary goiter should be treated in this way. Older patients, however, are treated medically. The development of cancer after 25 years would bring most of these patients beyond the average life expectancy of about 65. Thus, if current opinion were to be proved wrong concerning the initiation of cancer, the damage done would be numerically small.

On the other hand, in toxic recurrent goiter the efficacy of surgery is greatly decreased and the incidence of complications increased. Radioiodine still will induce either remissions or the development of hypothyroidism in all patients. For these reasons, then, the theoretical risk of late cancer has seemed less important than the practical advantages to be gained from the use of the isotope. Consequently these patients are treated by I₁₃₁ by preference.

Younger patients with glands which are too small for surgery to insure a satisfactory result, particularly when antithyroid drugs and x-ray therapy also have been tried and failed; patients with a shortened life expectancy due to complicating heart disease, diabetes or other serious disorders; and patients refusing surgery are considered to represent proper indications for I₁₃₁ therapy. The use of I₁₃₁ is contraindicated in pregnancy and nursing mothers since the isotope is collected by the fetal gland after the 3rd month of gestation¹⁰ and hence may do damage, and because the isotope passes into the milk.¹¹

The onset of severe infiltrative ophthalmopathy (malignant exophthalmos) of Graves' disease is not avoided by I₁₃₁ therapy any more than by any other therapy. However, with small doses given repeatedly the evidence suggests that the incidence may be significantly less than that after surgery so that I₁₃₁ given in this way may ultimately prove to be the method of choice.

The therapeutic result of the administration of a single dose of I_{131} is unpredictable. Approximately two of three patients will enter remission and one will remain hyperthyroid. Unfortunately no prediction can be made into which group a given patient will fall. There seems to be a factor of biologic variability in response to radiation effect which enters into the outcome. Hyperthyroid patients with unusual sensitivity and resistance of the gland to the radiations released by the breakdown of I_{131} have been seen, and there is as yet no method of distinguishing these from patients with glands of average sensitivity. An analysis of our early studies with a single dose of 3-4 mc. I_{131} revealed a tremendous spread in values for roentgens equivalent physical (r.e.p.) delivered to the gland.¹² Average dosage in those patients entering remission was 5000-7000 r.e.p. Nevertheless, success was achieved from as little as 2000 r.e.p. and failure with well over 10,000 r.e.p. In fact, hypothyroidism was induced in one patient with 2690 r.e.p. On the other hand, almost a third of patients not entering remission received 5000 r.e.p. or more.

USE OF ANTITHYROID AGENTS

There is a delay of about six to eight weeks before remission is induced by therapy with I_{131} . For this reason, antithyroid agents have been given to control the thyrotoxicosis in the interim before euthyroidism is achieved.^{13,14} If the patient has been receiving these drugs prior to the contemplated I_{131} therapy, treatment is stopped for a few days and if a high level of uptake reappears, the patient can then be given a therapeutic dose of the isotope and the antithyroid drug therapy can be resumed after several days. If the patient has received no previous therapy, I_{131} can be administered at once and treatment with antithyroid drugs started as early as 24-48 hours thereafter.

The antithyroid agents appear to help control the thyrotoxicosis, although causing a reduction in the efficacy of the radioiodine. Iodides particularly seemed to interfere with radiation effect.¹⁴ For this reason iodides are preferably not used except for emergency purposes; and somewhat more I_{131} is given than to patients not receiving antithyroid drugs. It is usually advantageous to stop antithyroid drug therapy 2 or 3 weeks before the appraisal of the I_{131} effect is to be made. Although I_{131} uptake may be resumed by several days after cessation of dosage, the clinical status may not be interpretable for several weeks.

As stated, a somewhat higher total dose of I_{131} is required in those patients receiving supplementary antithyroid drug, both in toxic nodular and toxic diffuse goiter. Certain patients with toxic nodular goiter may show extreme resistance to I_{131} as brought out by McCullagh and his group,¹⁵ but the average dosage requirement for toxic nodular goiter in New York, a nonendemic area for goiter, has been found to be little more than that for toxic diffuse goiter.¹⁶ This is in contrast to the findings in the endemic goiter area of the midwest.

However, whether toxic nodular goiter should be treated at all with I_{131} is a moot question. The incidence of cancer in toxic nodular goiter (0.9 per cent) is slightly higher than in toxic diffuse goiter (0.3 per cent). In older patients with toxic nodular goiter unable to be operated upon, the choice of I_{131} therapy does not seem unreasonable. These patients deserve an effort at definitive therapy and the prospect of later cancer is often less disturbing than that of immediate surgery. Substernal extension of goiter, however, should preclude the use of I_{131} . There is a distinct possibility of edema being induced by radiation effect and hence of tracheal obstruction.

CONCLUSIONS

In conclusion, it would appear advantageous for purposes of emphasis to summarize the indications for I_{131} therapy, although it is immediately to be recognized that such an outline is based upon personal views and is consequently subject to difference of opinion.

A. Primary untreated toxic goiter. Under age 40 or 45, surgery or other therapy than I_{131} is indicated because of the unanswered question of late cancer; over this age, I_{131} . Exceptions have been mentioned above.

B. Recurrent toxic goiter. The practical advantage of I_{131} therapy is its virtually 100 per cent remission or hypothyroidism rate and this is considered to outweigh the theoretical possibility of late cancer since repeated surgery offers a greatly reduced remission rate and an increased incidence of complications.

C. The small gland. Surgery is considered by many to be contraindicated because of the increased incidence of recurrence of hypothyroidism.

D. Juvenile hyperthyroidism. I_{131} should not be used. However, it is of interest that very small doses of I_{131} given weekly for 6 weeks induce a high percentage of remission in this age group.

E. Pregnancy and lactation. As stated above, I_{131} passes through the placenta and also into the milk. Use of the isotope is therefore contraindicated in these patients either therapeutically or diagnostically. However, in the first two months of pregnancy before the fetal thyroid becomes active, doses of I_{131} given inadvertently have not caused any evident harmful effects in the offspring.

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Central Africa Heard From

The initial copy of *The Central African Journal of Medicine* has appeared on the editor's desk. The publication of this journal for Rhodesia and Nyasaland has come as a result of the formation of the new State in Central Africa. The geographical position in the heart of the tropical world apparently has created a demand for recording the findings of physicians in that section and for exchanging views on the prevention of diseases peculiar to that area.

The first issue (January 1955) contains a long historical editorial on David Livingstone, messages from the president of the Royal College of Physicians in England and from the Secretary of Health of the Federation of Rhodesia and Nyasaland, five interesting scientific articles, a special section on "The Fevers of Africa," and two reports of medical society proceedings. The cover is attractive and the type good.

The editor expresses the hope that his journal may offer leadership in progress toward better health by becoming a "medium wherein opinions and experiences of doctors can find expression." The JOURNAL offers its sincere wishes for a successful and useful life to this neophyte from far off Africa.

State Journal Advertising

The year 1954 showed a gain over 1953 of 2,244 advertising pages in the 33 state medical journals which are members of the State Journal Advertising Bureau. This is an increase of 22.3 per cent and is well above the average gain for medical publications. This progress is not a result of increased advertising rates but represents the greater acceptance by leading firms of this group of journals as advertising media. Continued improvement in reading content and format during the past ten years together with more attractive cover designs have played an important part in the development of increased advertising sales. With an improvement in attractiveness and content has come an increased reader interest.

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CALL

ANNUAL MEETING OF THE HOUSE OF DELEGATES

The 1955 Annual Meeting of the House of Delegates will be held in the Music Room of the Stratford High School, Stratford (use King Street entrance) commencing at 10:00 o'clock in the morning of Tuesday, April 26.

Following luncheon, the House will reconvene for the completion of business.

H. M. Marvin, President
Creighton Barker, Secretary

Council Meeting

The monthly meeting of the Council was held at the offices of the Society on February 17, 1955. The meeting was called to order by the Chairman at 4:00 P. M. There were present in addition to the Chairman Dr. Danaher, Drs. Marvin, Stringfield, Couch, Barker, Weld, Gildersleeve, Gibson, Feeney, Fincke, Gallivan, Tracy, Russell, Labensky, Ottenheimer, Gens, Clarke, Dwyer, Archambault, Gilman. Absent: Drs. Murdock, Ursone, Flaherty, Walker and Buckley. Mrs. Josephine P. Lindquist of the office staff served as secretary and recorder during the early part of this meeting in the absence of the executive secretary who was at a legislative hearing in Hartford.

Dr. Marvin reported on the first meeting of the New England Planning Committee for the Interim Session of the AMA that is to be held in Boston in December 1955. Dr. Marvin read the minutes of the meeting and there was discussion concerning entertainment by Blue Shield Plans at a cocktail party for the House of Delegates. It was voted that the Council disapproved of CMS entering into any agreement to entertain delegates at a cocktail party, but did approve the sharing of dinner expense of delegates on a per capita basis with the other New England States. It was agreed that Connecticut State Medical Society would not have a separate headquarters.

Vincent J. Turco, Hartford, was appointed to the Civil Defense Casualty Planning Committee in charge of orthopedics and Charles Barbour, Jr., West Hartford, was appointed to the committee in charge of blood and derivatives.

Louis O. LaBella, Middletown was appointed to the AMEF Committee to replace Harry Frank, resigned.

It was voted to recommend to the House of Delegates at its Annual Meeting on April 26, 1955 the appropriation of \$2,500 from the surplus funds of the Society for the purpose of providing five (5) medical school scholarships in the manner followed in 1953 and 1954.

The next steps in the development of Employees Retirement Program were presented by Dr. Gallivan, chairman of the committee (AMB 10/13/54 "C"). The following action was taken:

(A) Voted: to retain Wiggin and Dana (Mr. Thomas) as Attorney to confer with the Connecticut General Life Insurance Company in drawing up the trust agreement and obtain approval of pension plan and pension trust from the Bureau of Internal Revenue.

(B) Voted: to approve the Second National Bank of New Haven as Trustee under the pension trust.

(C) Voted: appoint John N. Gallivan, Edward J. Ottenheimer and Cole B. Gibson as Pension Committee as provided for in the proposed plan.

In case the House of Delegates does not approve the pension plan at its Annual Meeting on April 26, 1955, the above details shall be cancelled and inoperative.

A request from the State Health Department for increased cancer control fund in the biennial budget 1955-57 (AMB 2/17/55 "A") was discussed at length. Requests for funds to be allotted to hospital tumor clinics is increased from \$50,000 to \$75,000 per year and funds for division of cancer and other chronic diseases are also increased.

It was agreed that the secretary of the Society should accept appointment on the Legislative Committee to the Connecticut Cancer Society which has been appointed to further this increased budget request of the Health Department and that the State Medical Society should express its approval of the increase to the appropriation committee of the State Legislature.

A Report of the Special Committee to Review the Commission Reports on the Establishment of a Medical School in the University of Connecticut had been presented to the members of the Council just prior to the meeting (AMB 2/17/55 "B"), and was briefly discussed. Because of the short time that had been available to study the report, it was voted to postpone definitive action until the next regular or possibly special meeting of the Council.

Dr. Danaher reported for the Nominating Committee (AMB 2/17/55 "C") and the Nominations as presented were all approved and will be published in the agenda for the Annual Meeting of the House of Delegates April 26, 1955.

An invitation was presented from the American Medical Association for the Society to submit the name of a member to be considered for the 1955 Distinguished Service Award of the AMA. Three or four names were discussed and it was voted that the name of John Rodman Paul, New Haven, should be submitted and the secretary was directed to take appropriate steps to provide the Board of Trustees of the American Medical Association with biographical data concerning Dr. Paul.

A request from the Committee on Public Health that the Society approve of the tentative plans for additional field trials in Connecticut of poliomyelitis vaccine was presented. Approval was voted of the following excerpt from the minutes of the Committee on Public Health, February 10, 1955:

"Since the report from Thomas Francis of Michigan was expected some time in April, he requested

that tentative plans be approved by the State Society at this time so that they could be set up in operation once satisfactory proof was at hand that the vaccine is effective.

"It was stated that the following obtained:

"The National Foundation for Infantile Paralysis had agreed to furnish enough vaccine to immunize the following:

"(a) Children who participated in the 1954 field trials in the counties—Hartford, Litchfield and Fairfield, but who did not receive the vaccine—this would be the present 2nd and 4th grades in these three counties.

"(b) Children in the 1st and 2nd primary grades of all schools throughout Connecticut.

"It was estimated that this would involve 800 schools and approximately 121,462 children.

"It was recommended that this number be done in the schools using volunteer medical and nursing personnel as in the 1954 field trials."

It was voted to approve the proposal received from Edward T. Wakeman concerning the desirability of the establishment of Rehabilitation Center for all defects of communication, cleft lip, cleft palate, sight, hearing, speech, etc. (AMB 2/7/55 "D").

The following resolution was received from the Board of Governors of the New Haven County Medical Association and approved:

"Voted: that the Board of Governors of the New Haven County Medical Association recommends to the Council of the Connecticut State Medical Society that appropriate steps be taken by the Council to promote the nomination of Thomas P. Murdock, M.D., to succeed himself as Trustee of the American Medical Association."

It was agreed that the delegates to the American Medical Association from the Connecticut State Medical Society should take appropriate steps to implement the purpose of this resolution.

The following resolution from the Board of Governors of the New Haven County Medical Association was referred to the Society's Committee on Hospitals:

"The Board of Governors of the New Haven County Medical Association records its opposition to the practice of medicine by hospitals, and desires that the Council of the Connecticut State Medical Society be so informed and requested to take appropriate action to prevent such practice."

The meeting adjourned at 6:30 P. M.

Report of Special Committee to Study Commission Reports on Establishment of a Medical School

To Council of Connecticut State Medical Society:

In compliance with your request, this committee has studied the report of the "Alcorn Commission" and the 1952 "Lodge Commission" together with information furnished by your executive secretary and published data on the subject of medical education. We are honored to present the following report of our deliberations.

I. NUMBER OF PHYSICIANS

Authoritative reports and observations indicate no immediate shortage of physicians in Connecticut but the future will see a steadily increasing need for more physicians. This need will stem from many factors including increased demand by the public for full medical care, increased ability to pay—particularly with the aid of insurance plans—and the increasing use of physicians in capacities other than those which represent direct patient care. In addition, estimations of future population expectancies indicate an increase of Connecticut residents during the next ten years at a rate almost twice that of the other New England States. All these factors suggest that there will be a need for a proportionately greater number of physicians in the future.

II. OBLIGATION TO PROSPECTIVE STUDENTS

While, at present, Connecticut students have opportunities to study medicine which are approximately equal to those of other U. S. citizens, we believe that the State of Connecticut has an obligation to see that its properly qualified students have the best possible opportunity to enter medicine as well as other fields of higher education. It appears that such opportunities are rapidly diminishing as more and more schools become obligated to admit students from their own states or geographic regions by compacts or other agreements. The overall picture is that this difficulty will increase rapidly for the Connecticut applicant.

III. THE NATIONAL POOL

We are impressed by the fact that while this State has an adequate supply of new physicians each year, the majority of them are trained outside the State at the expense of funds contributed by other than Connecticut citizens. It is well established that the student himself contributes one-third or less of the

cost of his medical education. The remainder of this expense must be furnished by taxes from non-Connecticut citizens or by private capital—usually provided from other than Connecticut sources. It would seem not only a financial but a social obligation for any state to contribute its share to the education of at least its proportion of the national pool of medical graduates. Connecticut is not at present carrying its full share of this responsibility.

IV. IMPROVEMENT OF MEDICAL CARE

The quality of medical care in Connecticut has been and continues at a high level. One assumes that this will continue in view of the attractions of this State for highly qualified physicians. These facts should not deter but should stimulate us to further improve this level of practice and to increase the facilities for the continued education of our physicians. The establishment of a medical school in the Hartford area would have far-reaching beneficial effects on medical care in Connecticut. Such a school should be viewed as a positive good to be achieved if feasible and practical; it should not be thought of chiefly as a necessity forced on us by a quantitatively demonstrated need for more graduates. The school being a part of Connecticut University would have, as a state agency, a clear obligation to extend the benefit of its teaching and research facilities to the entire medical profession as well as to the public.

V. REGIONAL COMPACT

Should Connecticut fulfill its obligations by providing the means for medical education of its qualified youth, some form of higher education agreement with regional states seems most desirable. The experience of several states with medical colleges indicates that restriction of admissions to one's own citizens often results in the necessity of admitting candidates with less than desirable qualifications in order to fill classes to such numbers as are needed for efficient operation. By providing the school itself, Connecticut would be assured of the quality of education offered and the management of the physical facilities for which it has contributed money, at the same time being assured, under regional compact, of sufficient candidates of good premedical qualifications.

FINDINGS

Your committee finds that the Connecticut State Medical Society should view with favor the pro-

posed establishment of a medical school as a part of the University of Connecticut, said school to be located in Hartford and operated by Connecticut under a regional compact. By so doing, we will support a project which will (1) meet the future needs for medical education of our youth, (2) discharge a financial and social obligation to furnish our share of physicians to the national pool and (3) provide a major and continuing contribution to the health and welfare of this State by the school's direct and indirect contribution to the quality of medical practice.

In making this recommendation, we wish to emphasize that only the highest quality of medical education should be offered and to this end that some permanent liaison should be established between this society and those responsible for the school's operation.

RECOMMENDATIONS

1. That the Connecticut State Medical Society favor the establishment of the proposed medical school under a regional compact.

2. That the Council direct the Legislative Committee and others it may designate to provide active support for such a project.

3. That the Connecticut State Medical Society offer its services and abilities in aiding the State in setting up this school.

4. That an advisory committee from the Society to the school be established as a part of the permanent pattern of its operation.

Dr. David J. Cohen

Dr. Frank H. D'Andrea

Dr. Chester Fairlee

Dr. Herbert Thoms

Dr. Louis P. Hastings, Chairman

Meetings Held

- March 1—Committee on Cooperation with Yale School of Medicine
- March 2—Committee on Maternal Mortality
Committee on State Medical School
- March 3—Professional Policy Committee of CMS
Committee to Study Third Party Payments for Medical and Ancillary Non-Surgical Services
- March 7—Conference Committee with Connecticut Pharmaceutical Association

- March 8—Conference Committee with Connecticut State Dental Association
Connecticut Medical Examining Board
- March 9—Connecticut Medical Examining Board
Committee to Study Neonatal Mortality
Board of Directors of Connecticut Health League
- March 10—Connecticut Medical Examining Board
Committee on Public Health
Committee on Veterans Medical Care
Woman's Auxiliary
- March 13—Committee on State Legislation
- March 16—Committee on Blood Bank
Committee on Industrial Health
Board of Directors, Connecticut Medical Service
- March 17—Committee on School Health
Committee on Art Exhibit (Woman's Auxiliary)
- March 22—Connecticut Medical Examining Board
- March 28—Connecticut Health League

The State Medical School

Dermont W. Melick, M.D. secretary of the Arizona Commission, Western Interstate Commission for Higher Education, speaking before the annual meeting of that State Medical Association estimated the annual cost of maintaining a medical school in Arizona (which does not have one at present) would be \$1½ million. The initial cost of construction he placed at \$16 million.

During his remarks Dr. Melick quoted from the dean of the University of Utah School of Medicine to the effect that "a number of state medical schools and private schools are finding faculty problems really tough—particularly in anatomy, physiology, pathology, radiology and psychiatry."

Arizona at the present time is operating under a compact with Colorado, Idaho, Montana, New Mexico, Oregon, Utah and Wyoming. Under this arrangement students are subsidized in medical schools existing in any one of these States. These subsidies must be repaid by the students either in services or cash. Arizona, according to Dr. Melick, should wait till 1970 when they have attained a population sufficiently large to justify introducing proper legislation for the establishment of a medical school.

NEWS FROM WASHINGTON

The medical services report of the Hoover Commission (on Organization of the Executive Branch of the Government) was sent to Congress on February 28.

The more important recommendations: 1. Establish a Federal Health Council. 2. Provide contributory health insurance for military dependents and for personnel of the Coast Guard, the Public Health Service and the Coast and Geodetic Survey, and for dependents of the latter three groups. 3. Regionalize military medical services, with one service responsible for each region. 4. Tighten up ability to pay requirements in VA, and codify VA laws and regulations. 5. Virtually wipe out the present Public Health Service hospital and medical care program.

Task Force studies determined that U. S. spending for medical programs and compensation totals \$4.1 billion a year and that the federal government is responsible in whole or in part for the medical care of 30 million people.

It is expected that legislation shortly will be introduced to carry out the recommendations. In a legislative sense, the Commission and Task Force suggestions carry only what weight the Congress wants to give them. The major medical recommendation of the first Hoover Commission (1949) was for a United Medical Administration to take over most of the medical responsibilities of the federal government. Hearings were held in Congress on this recommendation, but it was not put into effect.

Federal Advisory Council of Health

The Commission describes the present federal medical services as in a condition of "chaos." To help correct this it proposes that the President appoint a Federal Advisory Council of Health, to be made up of physicians and lay members. The Council would take over functions of the Health Resources Advisory Committee (Rusk) to the Office of Defense Mobilization and the Advisory Committee to Selective Service and would advise the President on all federal medical matters, including construction of facilities, training of U. S. medical personnel and military medical manpower.

Care for U. S. Beneficiaries and Potential Beneficiaries

(Merchant Seamen, Military Dependents, U. S. Employees, etc.)

Elimination of the present medical care program for merchant seamen, furnished by Public Health Service (at a cost of \$14 million in 1954). The Commission maintains that the U. S. no longer has any obligation to care for this group.

Contributory health insurance programs are recommended for military dependents and for Coast Guard, Public Health Service and Coast and Geodetic Survey personnel and for their dependents; the U. S. would contribute more toward health insurance for military dependents, CG, PHS and CGS than for other U. S. employees. If beneficiaries were treated in government facilities, the insurance carrier would reimburse the government.

Military medical facilities would provide for PHS, CG and CGS personnel and dependents pending establishment of the health insurance programs. Thus there would be little need for the existing PHS general hospitals and clinics, in the opinion of the Commission. The Commission recommends closing out the PHS general hospital care program, at a saving of \$19 million a year. (This was not a Task Force recommendation.) PHS would, of course, continue to maintain its special-type hospitals and clinics and its research clinics.

Veterans Administration Hospital and Medical Care Programs

The Commission says flatly: "There are more veterans' hospitals than necessary." Immediate closing of certain hospitals is recommended by the Medical Task Force, but the Commission modified this by recommending that the VA consider these recommendations and consult with the Health Council on them. The Commission does recommend that all hospitals determined to be surplus "be closed immediately," and that "all present outstanding authorizations and appropriations for construction of additional VA general hospitals be rescinded except for those now under construction or under contract."

Although the Commission finds that "the outstanding need of VA is for a firm legal basis for determination of eligibility for medical care of veterans with nonservice connected disabilities," it does not accept all Task Force recommendations in this direction. The Task Force proposes all nonservice connected care be ended three years after separation from service. But the Commission believes that "a sick and really indigent veteran should be provided care . . ." It recommends that the inability to pay statement (form 10-P-10) of a nonservice connected patient be subject to VA verification and that he be liable for costs if able to pay.

The Commission also proposes that the veteran with service connected disabilities should be required to sign the affirmation (10-P-10), if applying for treatment of a nonservice connected disability. Nonservice cases should be offered outpatient care when available, in the opinion of the Commission.

It is proposed that VA's authorization to collect for treatment of nonservice connected cases be extended by law to "some reasonable time in the future," when the veteran may be able to pay. This would apply in all nonservice cases, with the veteran asked to sign a noninterest bearing note.

The Commission found laws and regulations relating to veterans medical care to be in a confusing state. It recommends that they be consolidated and enacted as a single statute. Also, VA is advised to place more emphasis on medical care and rehabilitation services for aging veterans. Other recommendations to VA: Consolidate medical care functions of regional offices with VA hospitals, and where practicable locate the regional medical units within the hospital; transfer responsibility for medical criteria for disability from the Compensation and Pension Branch to the Department of Medicine and Surgery.

The Problems of Military Medicine

The Task Force declares that the amount of hospitalization given to uniformed personnel is "generally excessive and strongly influenced by administrative considerations," and that the result is unnecessary investment in hospitals "and inefficient use of facilities and manpower." The Commission's remedy would be to "regionalize" military medical care, with responsibility in each region assigned to the particular service having the major interests in that region. Thus there would be a degree of unification within the regions, but Army, Navy, and Air Force each would have certain

regions for which it would be responsible. The Commission believes that the change could be effected in such a way that proportionately each of the three services would have about the same total responsibility as at present. "As a result," the Commission says "many small facilities could be disposed of." Special hospitals—Tbc, mental, etc.—would care for patients from all three services.

On the Doctor Draft Act extension, the Task Force reported that the regular draft could supply all the necessary physicians. The Task Force also proposed a physician-troop ratio of three per 1,000. The Commission decided that the question of ratios should be left up to the Defense Department. It did not take a definite position on the Doctor Draft extension, but recommended that the Secretary of Defense, with the help of the Health Council, "develop recommendations for revision of the Selective Service Act to effect maximum utilization of medical personnel."

Other Recommendations of Commission

NATIONAL MEDICAL LIBRARY

Make the present Armed Forces Medical Library into a National Library of Medicine under supervision of the Smithsonian Institution; insure it adequate finances.

HILL-BURTON REAPPRAISAL

The Health Council should review and reappraise the Hill-Burton hospital construction program with particular attention to such problems as (a) validity of bed-ratio standards, (b) regionalization of hospital services and (c) relation of the small community hospital to total hospital program.

MEDICAL SUPPLIES PROCUREMENT

A uniform system of medical supplies procurement used by different agencies should be set up, thus eliminating separate catalogues. Complete recommendations in this field will be made by the Task Force on Supply.

PREVENTIVE HEALTH SERVICES

Federal council directed to make recommendations to improve preventive health services, particularly for such beneficiaries as military dependents, Public Health Service dependents.

MEDICAL RESEARCH

Health Council charged with coordinating federal research programs, encouraging research in broader areas and eliminating time limits on grants.

HEALTH PERSONNEL TRAINING

President is urged to review various U. S. health personnel systems to see if a more uniform method of recruitment, training and assignment can be effected. Medical personnel should be assigned to duties outside their own service where needed. Secretary of Defense should strengthen armed services programs for interns and residents, for other doctors on active duty and for reserve officers not on active duty.

FOOD AND DRUG ADMINISTRATION AND
AGRICULTURE DEPARTMENT

Food and Drug Administration, Agriculture Department and Budget Bureau to review areas of overlapping and possible duplication in FDA and Agriculture programs, and to determine if some services are no longer necessary.

PUBLIC HEALTH GRANTS

Secretary of HEW to reconsider the use of specific grants to states for health purposes, "particularly in relation to the inflexibility of the present system."

MENTAL HEALTH

The Health Council to promote cooperative planning among U. S. agencies providing psychiatric care, and the military services and VA to give greater emphasis to preventive psychiatry, PHS to encourage more research and training of mental health workers.

CIVIL DEFENSE

The U. S. to arrange for the appropriate delegation of operational authority for directing medical care in the event of an atomic attack.

A number of Task Force recommendations were omitted from the Commission report. They include grants to schools of public health, higher administrative ranking for chief health officials of the Departments of Health, Education, and Welfare and of Defense, removal of the Children's Bureau from the Social Security Administration, and improved grants programs for public health and mental health.

Some Commission Schemes at Odds With Task Force

Examination of final report of Hoover Commission's Task Force on Federal Medical Services discloses some differences between this expert advisory

group and parent Commission. Abolition of PHS hospitals was not recommended by task force. On veterans' care, latter proposed a three year cutoff (following discharge) in nonservice connected cases whose effect would be to reduce potential patient load from 21 million to seven million; but Commission rejected cutoff plan and suggested, instead, that nonservice connected load be reduced through closer financial screening of applicants and requiring this type of hospital admission to pay for services rendered if and when he could afford to do so. Commission withheld indorsement of task force recommendation that doctor draft law be allowed to die next June 30.

Bipartisan Bill Would Aid Medical School Expansion

Latest Democratic move to trump President's national health proposals is a \$250 million, five-year Federal program of Federal aid in expansion and construction of medical schools. Although two Republicans are on the bill—Senators James Duff (Pennsylvania) and Edward J. Thye (Minnesota)—its main backing will come from Democratic side. Prime sponsor is Senator Lister Hill (D—Alabama) and co-sponsors include Senators Hubert H. Humphrey (Minnesota), H. H. Lehman (New York) and Paul H. Douglas (Illinois), all Democrats.

Financial aid for dental school construction is not provided for, but will be if sufficient interest is displayed. Grant would be limited to 50 per cent of project's cost. It could go as high as two-thirds for new schools, or for existing ones which give assurance of a five per cent increase in freshman enrollment. No institution could get more than \$3 million over the five year period. Rep. J. Percy Priest (D—Tennessee) will sponsor companion bill in House.

New Senate Legislation

S929—Practical Nurse Training Program. (Hill, D—Alabama; Murray, D—Montana; McNamara, D—Michigan; Lehman, D—New York; Neely, D—West Virginia, February 4.) Would amend Vocational Education Act of 1946 to establish a program for training practical nurses and auxiliary hospital personnel. The bill contains standards for States to follow in training and supervision, and provides for an advisory council of 6 to 10

members, one of whom would be a physician. State plans for training would require the approval of the U. S. Commissioner of Education. State allotments would be decided by a per capita-income-population formula, insuring relatively more assistance to low income States. No matching funds would be required from States until July 1, 1957, when a 25 per cent State or local contribution would be required. Beginning July 1, 1959, and effective thereafter, the federal government would put up only half the cost. If not used, funds could be carried over for one year. The bill would authorize a first year appropriation of \$5 million. Labor and Public Welfare.

S980—Federal Scholarships for Scientific Subjects. (Cotton, R—New Hampshire, February 8.) Would authorize the Commissioner of Education to award scholarships not to exceed \$1,000 in engineering, physics, chemistry “and other sciences closely related to engineering, physics, or chemistry.” The Commissioner of Education would decide whether to include medicine. This bill, like HR2179 emphasizes defense needs. It provides for limited subsistence allowance payable directly to the student. No subsistence payment would be permitted in HR2179, but the maximum scholarship would be \$2,000. Other features of the two bills are quite similar. Labor and Public Welfare.

S999—Removing Limitations on Outside Income for Social Security. (Bender, R—Ohio, February 8.) Identical with HR27 and similar to HR3465. S999 would be effective after December, 1955. Finance.

S1076—Loans to Nonprofit Health Associations. (Humphrey, D—Minnesota, February 15.) Would assist voluntary nonprofit associations offering prepaid health service programs to borrow money. Such loans would be long-term and interest-bearing and probably would be evidenced by debentures or bonds and coupons. However, nothing is said about security; there is no requirement in proposed law that facilities to be constructed be mortgaged for the loan. Loans would be to finance purchase of equipment and facilities, and Senator Humphrey's office advises it is intended that acquired facilities secure the loan. Similar to HR399. One difference: S1076 pegs the interest rate at 2 per cent; whereas HR399 prescribes the interest as the going rate that the federal government pays (higher

than 2 per cent at the present time). Also similar to Mr. Humphrey's bill, S1052, of the last Congress. Labor and Public Welfare.

New House Legislation

HR3893 — Medical Expense Deductions. (Curtis, R—Missouri, February 10.) Would repeal for taxable years beginning after December 31, 1954, the maximum limitations on allowances for deduction for medical expenses. Presently the deductions are limited to \$2,500 per exemption, to \$5,000 if taxpayer is single and not the head of a household or is married but files separately and to \$10,000 if taxpayer files jointly. Ways and Means.

HR3911 — Medical Expense Deductions. (Bolton, O. P., R—Ohio, February 10.) Would remove: (1) The 3 per cent and 1 per cent of adjusted gross income not deductible, thus permitting deductions of all medical and drug costs for income tax purposes; (2) All maximum limitations for costs of sickness as explained in HR3893 above. Also broadened would be the deductions for “medical care” by adding to the amounts deductible for accident or health insurance, the amount paid for “subscription charges or other payments to prepayment cooperatives or other health or medical service plans.” This bill is similar to Mr. Bolton's HR3911 (same number) of the 83rd Congress. Ways and Means.

Medico-Dental Scholarship Bill Cleared by Pentagon

After a year's delay, Defense Department has sent to Capitol Hill its version of a bill to set up a military scholarship program in medical and dental schools. As watered down by Budget Bureau, however, the plan may find less favor with the deans than was the case when it was put out for “feelers” more than a year ago. Pentagon's final version is anything but clear on how scholars shall be selected; it sets up an advisory body that would not necessarily have to have a representative of medical or dental education, and it offers no financial inducement to the schools.

300 Medical, 126 Dental

Army Secretary Robert T. Stevens, urging passage of the bill, says there is now a shortage of 2,300 regular medical officers in Army, Navy and Air

Force and "a comparable situation exists in respect to regular dental officers." It is planned, he said, to offer sufficient scholarships to obtain 300 medical and 126 dental graduates annually for obligatory military duty.

Students participating one year or less would agree to serve in uniform for three years, or one year in addition to their regular draft obligation. Those participating more than one year would be liable to a total of four years' duty. Scholars would receive a \$133 monthly stipend, schools the "usual tuition, fees and laboratory expenses." Cost to government in first year of operation is estimated at \$2,542,000.

Medical Advisory to Social Security

The new Medical Advisory Committee to the Social Security Administration is headed up by J. Duffy Hancock, past president of the Kentucky State Medical Association and professor of surgery at the University of Louisville School of Medicine. This committee will develop recommendations on the standards and procedures to be applied by state agencies in determining disability. Determinations of disability will be necessary when workers apply for the "disability freeze" authorized in the 1954 amendments to the Social Security Act.

The other members of the committee are:

Alexander P. Aitken, clinical professor of orthopedic surgery of Tufts Medical College and director of the Liberty Mutual Rehabilitation Center, Boston, Massachusetts; Miss Pearl Bierman, consultant in medical social work with the American Public Welfare Association, Chicago, Illinois; Donald Covalt, associate professor, Department of Physical Medicine and Rehabilitation, New York University College of Medicine, New York City; Charles L. Farrell of Pawtucket, Rhode Island, president-elect of the Conference of Presidents and other Officers of State Medical Associations; J. S. Felton, associate professor, Department of Medicine and Department of Preventive Medicine, University of Oklahoma, Oklahoma City; Herman E. Hilleboe, commissioner of the New York State Department of Health; Lemuel C. McGee, medical director of Hercules Power Company at Wilmington, Delaware; Kenneth E. McIntyre, director, United Automobile Workers, CIO Health Institute, Detroit, Michigan; William A. Pettit, State supervising ophthalmologist for the California Department of Public Wel-

fare at Los Angeles; Leo Price, director of Union Health Center, International Ladies Garment Workers Union, New York City; W. H. Scoins, chief medical director, Lincoln National Life Insurance Company, and chairman, Medical Relationships Committee of the Health Insurance Council, Fort Wayne, Indiana; Carroll Shartle, PH.D., professor of psychology, executive director of the Personnel Research Board, Ohio State University, Columbus, Ohio; Mr. Byron Smith, member of the Board of Trustees of the American Foundation for the Blind, a director of National Industries for the Blind and executive secretary of the Minneapolis Society for the Blind; and David Wade, medical consultant for the Texas Division of Vocational Rehabilitation, Austin, Texas.

Priest Heads House Subcommittee on Health Legislation

Chairman Priest (D-Tennessee) of the House Interstate and Foreign Commerce Committee has named a subcommittee to handle health and science legislation, with himself as chairman. Other Democratic members are Reps. F. Ertel Carlyle of North Carolina, Kenneth Roberts of Alabama, Martin Dies of Texas, Torbert Macdonald of Massachusetts and Don Hayworth of Michigan. Republican members are Reps. Charles Wolverton of New Jersey, John W. Heselton of Massachusetts, Richard Hoffman and William Springer, both of Illinois, Joseph L. Carrigg of Pennsylvania and Steven Derounian of New York.

New Regulations Recommended for Aspirin and Salicylates

A special advisory panel to the Food and Drug Administration has made a number of recommendations for tightening up on the packaging and distribution of salicylate-containing preparations, mainly to safeguard children. The recommendations are:

1. Labels of all bottles and packages of salicylate-containing preparations should carry the following minimum statement in bold-face type: "Warning: Keep out of the reach of children." (2) Unless the labeling contain specific dosage recommendations for children under three, this warning should be carried: "For children under three, consult your physician." 3. Dose forms of several strengths of

children's aspirin are undesirable and manufacturers, wherever possible, should concentrate on a standard strength of children's aspirin of one and one-fourth grains per dosage unit. 4. Manufacturers should not increase their present maximum amounts of children's flavored aspirin per package unit, and development of a safety closure and container should be encouraged. 5. Wider and more effective educational means should be used to inform physicians, pharmacists, and consumers of the hazards involved in accidental ingestion of salicylate-containing preparations.

Representatives of all leading producers of salicylate-containing preparations took part in the panel discussions and concurred in the recommendations. Also participating were deans and professors of colleges and officials of the Food and Drug Administration. Bernard Conley represented the American Medical Association's Committee on Toxicology.

In explaining the committee's suggestions, Dr. Albert H. Holland, Jr., FDA medical director, said the preparations in question are ordinarily safe in the amounts required for producing an analgesic action, but because their use is familiar to everyone "the public has come to regard them as entirely innocuous." Actually, he said, "aspirin and other salicylates are capable of causing injury and even death when consumed in excessive quantities." Dr. Holland said that in 1952 there were 113 fatal salicylate poisonings, including 86 children under five years of age. Of the latter, 65 involved aspirin, sodium salicylate or a salicylate not further identified, while the others were due to menthyl salicylate.

After studying the recommendations of the panel, FDA will decide what new procedures to put into effect.

Blue Shield Reports

At the annual meeting of Connecticut Medical Service Mr. Judd, president, reported an increase of 24 per cent in membership for 1954 bringing the total to 865,941. This was the largest increase in any single year since 1950 and is all the more outstanding because the past year represented the first year of independent operation for CMS. The volunteer surgical-medical service plan paid 133,000 claims during the year amounting to almost \$7 million. At the end of the year more than 266,000 persons were covered by the Preferred Contract, and during the

year 230 additional physicians joined as Participating Physicians, bringing the total of the latter to 2,373. During the year two out of every three CMS members receiving care by a physician had their entire doctor's bill covered by a CMS contract.

In the annual elections of the Board of Directors, Mr. Judd, who resides at Hamden, was re-elected president. Other officers re-elected included Dr. Thomas J. Danaher of Torrington, vice-president; Dr. Louis F. Middlebrook of Hartford, secretary; and Carl G. Freese of Hamden, treasurer.

Re-elected to the Board of Directors, in addition to Mr. Judd, Dr. Danaher, Dr. Middlebrook and Mr. Freese, were Dr. Henry A. Archambault of Taftville; Dr. Creighton Barker of Hamden; John Coolidge of Farmington; J. Edison Doolittle of Milford; William B. Gumbart of Hamden; Franklin R. Hoadley of Hamden; Dr. Thomas P. Murdock of Meriden, and Dr. Walter I. Russell of New Haven. All officers and members of the Board serve without salary.

The Board also re-appointed to the plan's Professional Policy Committee Dr. Danaher, who serves as the committee's chairman; Dr. Archambault; Dr. Orpheus J. Bizzozero of Waterbury; Dr. Thomas J. Feeney of Hartford; Dr. Robert G. Reynolds of Hartford; Dr. Russell; and Dr. Edward J. Whalen of Hartford.

In addition, the Board approved two changes in the CMS By-Laws, affecting the make-up of the Professional Policy Committee, whose job it is to determine the type of professional services covered by the CMS Contracts. The changes provided for the appointment to the committee of the president and president-elect of the Connecticut State Medical Society, by virtue of their offices, and for the direct election of three additional members of the committee by the CMS Participating Physicians, through their county associations. The elections for the three additional members will be completed in April.

Cardiac Surgery at Yale

The School of Medicine *Alumni Bulletin* of Yale University contains an account of the developments of cardiac surgery in the issue of January, 1955. This is a result of team work by two members of the full-time faculty, by members of the resident staff assigned to this section, by the cardiologists of the Department of Internal Medicine and Pediatrics, and by two full-time research fellows.

FIFTY YEARS OF PROGRESS IN MEDICAL EDUCATION

Medical education and the practice of medicine in the United States have established the highest standards in history.

The population of the United States increased 100 per cent in the past fifty years; medical school graduations increased 114.6 per cent; enrollments in medical schools increased from 12,500 to 28,200; and graduates increased from 3,165 to 6,860 annually.

Continued progress is threatened by the financial problems of the schools. Every physician can help by contributing to the 1955 campaign of the American Medical Education Foundation.

**Our Medical Schools Need
The Support of Every Physician**

Connecticut State Medical Society
160 St. Ronan Street
New Haven 11, Connecticut

Please send a contribution card and information concerning the American Medical Education Foundation.

Name

Office Address

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PUBLIC RELATIONS

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Middlesex County Initiates Public Information Program

The Middlesex County Medical Association recently inaugurated a long-range program of public information concerning health services available to residents throughout the county.

The program was initiated by publication and distribution of a new 16 page guide to health services during the March 21-27 observance of Community Health Week by local chapters of the Junior Chamber of Commerce in cooperation with medical associations.

Ideally suited for the theme of the week's activities, "Know Your Community Health Resources," the booklet was distributed to several thousand residents.

Dr. Harry C. Knight, Middletown, chairman of the Public Relations Committee of the Middlesex County Medical Association, has announced that distribution of the guide will be continued as a public service in cooperation with the Woman's Auxiliary to the Association. Distribution points will be selected with a view to assuring that persons who receive the booklet will understand its purpose and usefulness.

Dr. Willard E. Buckley and Dr. A. W. Thomson, Jr., of Middletown, both members of Dr. Knight's committee, assisted in compiling the new type of service publication.

Approximately five by eight inches, the booklet is prefaced with a description of the training and responsibilities of the family physician. The following pages describe the services of the Middlesex Memorial Hospital, the Ambulance Service, local Red Cross chapters, the Department of Health, the District Nurses' Association and other health facilities.

The booklet also contains a complete list of all physicians in the county, arranged by areas and by types of specialty or general practice.

Health Education Broadcasts Scheduled On Three Stations

Three community radio stations are now regularly broadcasting health education programs sponsored by the Public Relations Committees of county medical associations in cooperation with the Woman's Auxiliary.

In Fairfield County, a 13 week series, titled "Hi-Forum" may be heard each Monday at 7:30 P. M. The program concerns the health problems of teenagers and is presented from the studios of WSTC, Stamford.

"The Best Is Yet To Be," a program devoted to health problems of later years, is being broadcast in Litchfield County each Sunday at 1:30 P. M. from the studios of WCLR, Torrington.

Radio Station WCNX, Middletown, is broadcasting another health series each Saturday at 11:15 A. M. titled, "Chats With The Champs," the program comprises interviews on health problems with leading athletes.

The programs are 15 minutes in length and are transcribed on platters furnished by the American Medical Association's Bureau of Health Education. Members of the Woman's Auxiliary who have arranged the programs are Mrs. John Bucciarelli, New Canaan, Fairfield County; Mrs. Daniel P. Samson, Torrington, Litchfield County; and Mrs. Walter Nelson, Cromwell, Middlesex County.

New Haven County Participates in Health Education Project

The New Haven County Medical Association took an active part in co-sponsoring an AMA educational exhibit on nutrition as a feature of the "Do-It-Yourself" Show held at the New Haven Arena, March 29 through April 2.

The show is held annually by the *New Haven Register* and the *New Haven Journal-Courier* and is

attended by thousands of county residents interested in hobbies and crafts.

An invitation to participate in the project was approved by the Board of Governors following its presentation by Dr. James H. Root, Jr., Waterbury, chairman of the Association's Public Relations Committee. The exhibit was sponsored by the Nutrition Committee of the New Haven Council of Social Agencies.

Community Health Week Sees Many Local Activities

Many educational programs in communities throughout the State featured the first Community Health Week sponsored March 21-27 by the Junior Chamber of Commerce in cooperation with county and local medical associations.

Community hospitals and voluntary health organizations also cooperated in the observance, a nationwide project backed by the National Health Council. Keyed to the theme "Know Your Community Health Resources," the observance encouraged a variety of effective health education planning by leaders of the Jaycees. This response and interest is viewed as a strong indication that the observance may develop into an annual event.

Five Films Available for Community Programs

Local medical associations may now obtain films for community programs from a list of five specially selected subjects portraying various aspects of modern medical care.

The films are 16 mm. sound productions furnished by the American Medical Association and may be obtained through the offices of the State Medical Society. All films except one have running times of 27 minutes, the exception being one film titled, "Your Doctor" which has a running time of 15 minutes.

Titles of the other films are "A Life to Save," "Night Call," "A Citizen Participates," and "Operation Herbert." Full information concerning content of the productions may be obtained upon request. The films are furnished free of charge except return postage.

Two of the films which have proved especially popular are "Your Doctor" and "Operation Her-

bert." These were shown recently before church groups in West Hartford and Southport, and high school students in Saybrook, Windsor, Wilton and Stratford.

AMEF Leaders Attend Annual Chicago Conference

The Fourth Annual Meeting of state chairmen of the American Medical Education Foundation, held in Chicago, January 23, was attended by approximately 75 AMEF chairmen and medical society executives.

The conference was opened by Edwin S. Hamilton, trustee of AMA and a director of AMEF, who introduced Walter B. Martin, president of the American Medical Association.

Stressing the necessity of participation in AMEF activities by all physicians, Dr. Martin declared that "it seems inevitable that the American Medical Association and its component associations must take this project more seriously than in the past few years." He outlined the needs of the medical schools and the dangers inherent in proposals aimed at government subsidy of medical education.

Mrs. George Turner, president of the Woman's Auxiliary to the AMA, told of the progress made by chapters of the Auxiliary and reported that their total contributions to medical education during 1954 had exceeded \$50,000.

Other speakers on the morning program included Mrs. Frank Gastineau, national chairman of the Woman's Auxiliary for AMEF, Charles Ruggeri, president of the Utah State Medical Association, and D. W. Heusinkveld, president-elect, Ohio State Medical Association.

The story of Connecticut's activities was related during the afternoon session by James G. Burch, public relations director of the State Medical Society and William G. H. Dobbs, chairman of the Connecticut Committee, both of whom attended the meeting as guests of the Foundation.

Hiram W. Jones, executive director of the Foundation, presented several new proposals for fund-raising purposes and stressed the necessity of renewed efforts to raise annually the \$2,000,000 of physician contributions upon which is predicated an annual contribution of \$8,000,000, from industrial and other corporate donors.

FROM OUR EXCHANGES

Davison in dealing with "Changes in Medical Education and Patient Care" focuses attention on some needed medical truths (*The Jour. Florida Med. Assoc.*, XLI:3, pp. 175-184). His conclusions may be over-briefly summarized as follows:

1. The attention of the student and faculty should be focused on the patient, not solely as the site of a disease, but as a human being and as a member of his family and community with many other problems in addition to his illness.

2. There should be more outpatient teaching, home visits and preceptorial experience with the general practitioner to make the student and staff cognizant of the family, community and environmental relationships of medicine.

3. Premedical and medical education should be integrated and an accelerated curriculum used.

4. More funds are needed for medical students.

5. To maintain present standards more money is needed for medical faculty salaries, operating expenses, increased working space and other facilities.

6. The medical school should be reimbursed by States and counties for their professional care of indigent patients.

7. The expansion of medical schools should be adequately financed by State and federal funds. The demand for more physicians, especially for rural general practitioners, can be met in no other way.

8. Research is a necessity for sound medical education, but should be coordinated with teaching and not submerge it. Instructors should be appointed on the basis of their teaching ability and not solely on their prolific writing.

* * * *

According to Smith and Buchman the prodromal symptoms of myocardial infarction in 100 consecutive cases of myocardial infarction occurred in 48 per cent of the cases from three months to one day before the clinical picture of infarction appeared (*Jour. Iowa State Med. Soc.*, XLIV:9, pp. 412-415). In order of decreasing frequency the symptoms were sudden onset of anginal pain, unusual dyspnea, and abrupt change in the character of a previously existing angina pectoris.

* * * *

A contribution to medicine of uncommon value is that of Fleming under the title of "General Practice in America and Great Britain—Some Observations and Comparisons" (*Brit. Med. Jour.* 4876, pp. 1392-1402). The length of the analysis defies condensation into two or three brief paragraphs.

Dr. Fleming spent three months in this country under the aegis of the Rockefeller Foundation. He travelled widely and saw many medical schools and hospitals and visited patients with the general practitioner in his office and in his daily rounds. He found much that he could praise and a few things that he thought were better done in Great Britain.

The author did think that "more time might sometimes have been given to consideration of the patient as a person. It may be this is due to some measure of preoccupation with instrumental investigation, laboratory tests, x-ray examinations, etc.—and time as always is the enemy." He is of the opinion that the main needs of the general practitioner today are: (1) adequate time to do his work efficiently; (2) facilities to practice medicine in the way in which he has been taught, including his own accommodation, equipment, and staff, and access to special diagnostic and therapeutic services at hospital or elsewhere; (3) some useful form of attachment to hospital; and (4) regular and appropriate postgraduate training.

Health centers such as the Health Insurance Plan of Greater New York seem to meet with Dr. Fleming's approval, with the added proviso that "the essence of the scheme has yet to be added; it is the presence at these centers of the family doctor."

* * * *

Complete replacement of lost blood and emergency surgical operation in selected cases has resulted in the halving of the mortality rate at Christchurch Hospital in cases of acute gastrointestinal hemorrhage ("Treatment of Acute Gastro-Intestinal Haemorrhage with Particular Reference to Quantitative Blood Replacement." Gunz *et al.*, *Brit. Med. Jour.*, 4868, pp. 950-956).

Blood-volume estimations were based on the Gregersen (1944) Evans' technique. The patients were transfused by means of the continuous drip

method with either stored whole blood or packed red cells. The normal rate of transfusion was one pint in four hours. It is evident that hemorrhage in certain cases does not subside under conservative treatment. Two classes of patients were subjected to emergency surgical treatment: (1) those who, in spite of conservative treatment including adequate blood transfusion, showed evidence of bleeding at the end of 48 hours observation in hospital, the operation preceded by appropriate measures of resuscitation being performed as soon as such a diagnosis had been made; and (2) those who, following cessation of the original hemorrhage, showed evidence of recurrent bleeding while still in the hospital.

This study was based on the study of 88 cases admitted to Christchurch Hospital during one year after the adoption of the therapeutic regime whose principal feature was the quantitative replacement of the blood lost in acute gastroduodenal hemorrhage. The initial treatment by conservative measures and the early determination of blood volume and the repetition of blood-volume estimation seem to be of the utmost importance in determining the need for early surgical interference.

* * * *

Hayman (*G. P.*, X:3, pp. 35-38) in a discussion of the problem of "The Vaccination and Immunization History of Children Entering School" observes that it is generally conceded that all people should be vaccinated against smallpox and that all children should be immunized against diphtheria, pertussis and tetanus during the first year of life. The family doctor takes care of the bulk of pediatric practice and has therefore the chief responsibility for attaining this ideal. The author states that the family doctor is steadily doing a better job in accepting this responsibility, but still has a long way to go.

* * * *

The management of patients with essential hypertension, according to Jeffers, is always based on a careful clinical evaluation that requires a minimum of laboratory examinations. Mild or labile hypertension may require no treatment other than reassurance. Those patients deserving active treatment should be placed on a regime of general measures and to these measures may be added the use of depressor drugs such as a veratrum derivative, hydralazine or hexamethanum, with a due consid-

eration for their dangerous toxic effects. Surgical treatment is reserved for those well preserved patients who do not respond to the foregoing measures.

The surgical treatment suggested (*idem*, pp. 66-73) is thoracolumbar sympathectomy. Because this operation has failed to alter the pressure of severely hypertensive patients or has been followed by relapsing severe hypertension after a year or so the author has explored the effects of combining extensive adrenal resection with various types of sympathectomy in 125 patients during the last four years. Limited subdiaphragmatic sympathectomy combined with total or subtotal adrenalectomy gives results comparable with the more extensive thoracolumbar sympathectomy, and with less postoperative morbidity and disability. There has been an excellent clinical response in 34 per cent of severely hypertensive patients with this combined surgical approach. In an additional 19 per cent the results have been fair. Patients beyond 60 years of age have not been referred for operation, nor those with marked impairment of renal function (less than 20 per cent elimination of P.S.P. in the first fifteen minutes after intravenous injection; blood urea nitrogen more than 20 mg.).

Well preserved patients with severe hypertension who fail to respond to intensive medical therapy should not be denied the benefits of surgical treatment.

* * * *

"Methostan in the Treatment of Nutritional Dwarfism—A Preliminary Report" (*Jour. of Mich. State Med. Soc.*, 52:11, pp. 1181-1188) offers real hope that these children will attain something near their normal stature. There are only seven cases in the series but the results were all impressive. Methostan has an anabolic effect, stimulating weight and height. All seven children improved their emotional status, often dramatically. An additional child increased in stature and gained in weight when treated with Methostan but was not seen early enough before the beginning of fusion of the epiphyses to achieve normal stature.

Methostan was given daily in the form of one-half tablet or 12.5 mg. The dose was increased slowly depending on the response of the individual. Sometimes the dose was increased to one tablet or 25 mg. daily.

* * * *

Kern calls attention to "Our Growing Responsibilities to the Aged in Our Midst" (*Maryland State Med. Jour.*, 3:8, pp. 393-401). Those over 65 years now comprise 8 per cent of our population—and 11 per cent of those over 18 years. In a quarter of a century those over 65 will comprise 20 per cent of the workers over 18 years. A scant 5 per cent of those over 65 have saved enough to be self supporting. Another 25 per cent are still at work. About 70 per cent of these old people are being supported in whole or in part by others. The author expresses the belief that the most useful therapeutic measure in all aspects of treatment of the ills of aged is sympathy. The absence of reassurance and encouragement will result in failure because of the absence of the will to live.

* * * *

According to Matlin, Penicillin-PBZ (Pyribenzamine) has a reaction rate of only 1.04 per cent when given orally (*Amer. Pract. and Dig. of Treatment*, 5:10, pp. 761-762). The author concludes that the administration of an antihistaminic in combination with penicillin may have advantages over the use of penicillin alone when used in the treatment of sensitive individuals.

* * * *

Lautens draws the following conclusions concerning the value of gastroscopy (*Jour. of Kansas Med. Soc.*, LV:10, pp. 559-563). (The study is based on 250 gastroscopic observations.) The diagnosis in eight cases was proven wrong either by clinical follow-up or by surgery. In 11 cases the correct diagnosis was made only by gastroscopy. The importance of combining the use of x-ray and gastroscopy is stressed. In the author's opinion gastroscopy should be considered as a routine method of examination in every case of unexplained upper gastrointestinal symptoms.

* * * *

Convenience, saving of time for the physician and patient, and often an improved state of cardiac compensation appear to be major advantages in the treatment of congestive cardiac failure with oral mercurial diuretics. Doherty *et al* find the following guide to be useful in prescribing oral mercurial diuretics (*Amer. Pract. and Dig. of Treatment*, V:10, pp. 749-758).

- (1) Use the smallest effective dose to maintain dry weight.
- (2) Encourage the proper intake of fluids to insure maximum diuretic effect.

(3) Be alert for the development of signs of hyponatremia, hypochloremia, hypokalemia and overdigitalization—signs of "over-diuresis."

(4) Addition of ammonium chloride to the therapeutic program enhances the effect of mercurial diuretics.

(5) Adequate digitalization should be maintained.

The preparation used by the authors was Neohydrin (3-chloromercuri-2-methoxypropyluria). Other preparations are mentioned but Neohydrin seems to be the one of choice.

The caution necessary in administering the mercurial diuretic orally appeared to be no greater than that usually observed in the use of parenteral mercurial agents. Nausea, vomiting, diarrhea and a rising level of nonprotein nitrogen occurred in only 10 per cent of the patients treated.

The contraindications to oral mercurial diuretic therapy are essentially those of mercurial diuretics by any route. The contraindications may be briefly stated as uremia or the presence of severe renal disease; significant gastrointestinal disease and sudden or rapidly progressive cardiac failure.

* * * *

McLane and Heck (*Jour. of Med. Soc. N. J.*, 51:10 pp. 407-410) conclude from a rather extensive comparative series of observations that ordinary upper respiratory infections are best treated with a tablet containing aspirin 150 mg., phenacetin 120 mg., caffeine 30 mg., phenyltoloxamine dihydrogen citrate 25 mg., and procaine penicillin G 100,000 units. After a 72 hour test period with the penicillin-containing tablet, 65 per cent of the patients treated exhibited a complete remission of clinical signs and symptoms of upper respiratory infection. Parallel series treated with other combinations in common use showed only 13 per cent cures.

* * * *

A recent hazard in anesthesia has been discovered in anesthetizing patients who have been on long treatment with cortisone or ACTH and then have been taken off treatment with these hormones. If these patients are anesthetized and operated on they may go into sudden, fatal shock any time during the operation or during the first day after operation. ("Anesthesia Accidents" by Lundy, *Jour. of Mich. State Med. Soc.*, 52:11, pp. 1174-1176.) The author suggests that the next question after the inquiry about artificial teeth should be "have you ever been treated with cortisone or ACTH?"

REPORT OF THE MEDICAL ADVISORY COMMITTEE OF THE CONNECTICUT STATE MEDICAL SOCIETY TO THE WELFARE DEPARTMENT OF THE STATE OF CONNECTICUT

The Council of the Connecticut State Medical Society by authority granted to it by the House of Delegates of the Connecticut State Medical Society appointed the Medical Advisory Committee to the Welfare Department of the State of Connecticut at the Annual Meeting of the Society in April of 1954.

This committee, newly conceived and established, is a very responsible and potentially powerful instrument for providing good medical care to the State of Connecticut. Rather than a committee to guide the Welfare Department only, it is the organ through which the State Medical Society can advise the entire state government in its provision of the multimillion dollar care program now provided to state beneficiaries by practitioners of the medical arts. The committee meets with the Medical Affairs Reference Committee of the Commissioner of Finance and Control to work out medical problems, cooperatively. The Medical Affairs Reference Committee makes suitable recommendations to the Commissioner of Finance and Control for his guidance in issuing fee schedules and regulations governing payments of practitioners of the medical arts for their care of state beneficiaries, governing payments by all departments, agencies and institutions of the State.

Decisions of this Medical Affairs Reference Committee and recommendations made are governed by opinions of the Attorney General of the State of Connecticut as the interpretation of the statute that created the welfare program.

The Medical Advisory Committee has met on June 8, 1954; July 13, 1954; August 4, 1954; September 28, 1954; November 3, 1954; December 8, 1954; January 12, 1955 and February 9, 1955. Each meeting was well attended by the members of the committee and Harold F. Pierce, medical director to the State Department of Welfare, has been present at each meeting.

The revision of the fee schedule was the first matter taken up by the committee and was completed only after the seventh meeting. Much thought and effort was given to this subject and the advice

of each member of the committee was thoroughly discussed before the final product was evolved. The committee has representatives from different fields of medicine among the membership.

The committee made the following recommendation for revision of the fee schedule:

Schedule One: General Practitioners (M.D.); House Calls \$4.00.

Change: "Complete physical examination (to include routine urinalysis, hemoglobin, and blood for serology)" to read, "Complete physical examination (to include urinalysis, hemoglobin and blood for serology when indicated.)"

Schedule Three: Special Procedures:

Delete A. 3.

Change A. 4; to read, "Examination of eyes with refraction, manifest and/or under cycloplegic and measurement of tension; office \$10.00; at home \$11.00."

Delete B. 9.

Add: "Clinical Psychological examination with I. Q. determination, \$5.00."

Change B. 5, to read, "Electrocardiogram with interpretation only; plus one house call when done other than in office."

Schedule Four: Surgical Operations: It is the recommendation of the committee that payments for procedures surgical in nature, previously listed in this part of the Fee Schedule, be made on the basis of 80 per cent of Connecticut Medical Service Standard Contract.

Schedule Five: Clinical Laboratory Examinations and Reports: It is the recommendation of the committee that necessary laboratory examinations be carried out, whenever possible, by the State Department of Laboratories.

Urine examination:

Change "Calculus" to read, "Analysis of Urinary Calculus."

Change "Urinalysis" to read, "Urinalysis, routine and microscopic."

Under "Pregnancy:" to read, "Pregnancy test, animal, \$3.00."

Under "Hematology:" delete "Bone Marow." Add "Sickle Cell examination, \$3.00."

Under "Chemistry" add "Protein Bound Iodine, \$10.00." Delete "sulfonamide, thiocyanates, urea clearance and Total Protein, Cu or drop method (Chemical)."

Under "Bacteriology" delete "autogenous vaccine."

The committee again emphasized the use of facilities of the State Department of Health Laboratories for procedures in this schedule, when necessary.

Miscellaneous: Add "Radioactive Iodine Uptake, \$10.00." Add "Scotch tape test for infestation of pin worms, \$1.00."

Schedule Seven: It is the recommendation of the committee that tinting of lenses at \$1.10 per lens be allowed only on the prescription of an ophthalmologist who shall state the definite clinical indication for same.

The basis for change in lenses should be a change in vision of 0.50 sphere or 0.50 cylinder, but not both.

Armor plating of lenses is recommended and authorized for children at \$1.50 per lens.

The following recommendations and information were approved by the committee:

1. Practitioners should be allowed to use the adrenocortical stimulating hormones without requesting prior authorization from the Medical Director.

2. X-ray and radium therapy to be administered only by certified radiologists and dermatologists.

3. Routine x-ray examinations and routine laboratory examination be done only after securing prior authorization for such services.

4. Sera and vaccines for use in the care of beneficiaries of the State welfare medical program be obtained from local Directors of Health for which no charge is made for material.

5. The use of clinics and outpatient services for beneficiaries of the State welfare medical care program to be used at the discretion of the physician.

6. The elimination of the Unit System in the Fee Schedule.

7. Physicians acquaint themselves with the January 1, 1955 directive entitled, Revision of the Pharmacy Program of the Welfare Department as

it applies to beneficiaries of the State welfare program.

8. Physicians become acquainted with the following opinion of the Attorney General of the State of Connecticut rendered to the Commissioner of Finance and Control: "The broad supervisory powers of the Commissioner of Finance and Control over the fiscal management of every state department, board, institution and agency, as set out in Section 222 of the General Statutes of 1949; vest him with authority to promulgate a uniform fee schedule for payment of practitioners of the healing arts for their services to needy persons chargeable to the state. It is clearly a prerequisite to the expenditure of state funds for welfare purposes that such outlay cover only actual medical need in each case on the most economical basis consistent with professional fulfillment of such need."

9. Oral medication should be used whenever practicable. In hormonal therapy, oral medication should be used, conservatively, in preference to parenteral hormone therapy as suggested by the Council on Pharmacy of the American Medical Association.

10. In regard to specialist care: The committee is limited by an interpretation by the Attorney General which has the force of law. The statute states: "A beneficiary under an Old Age Assistance Award made under this chapter (Section 2867 of the General Statutes of 1949 as amended by Section 280a of the 1949 Supplement to the General Statutes), shall receive aid to the extent necessary to maintain a standard of living reasonably compatible with health and decency, provided in cases where said amount is insufficient to furnish necessary medical or hospital treatment to a beneficiary, the Commissioner of Welfare shall order the payment of such additional costs of medical care as he deems necessary and reasonable, and such additional cost of hospitalization as is provided in Section 275 and 276a." The opinion of the Attorney General of the above is quoted as follows: "In view of the foregoing, it follows that the beneficiary cannot subject the state to payment of higher medical costs than necessary by choosing his treatment nor by electing that it be dispensed by a specialist. Similarly a specialist may render services in such a capacity at his own election only at the peril of a finding by the Commissioner or other authority that specialist services are not necessary and that a payment at the rate accorded a general practitioner by the fee schedule is the maximum consistent with the term 'reasonable'."

The committee enquired as to the feeling of specialty boards in medical practice in regard to diplomates engaging in general practice and was advised that diplomates of boards are expected to confine their practice to the field of medicine in which they are certified. The only exception is in the case of community plans for disaster or emergency service, in which case the diplomate's status is not jeopardized by his participation on a temporary basis.

Rates for Workmen's Compensation Cases

Arrangements have just been completed for a new rate schedule for workmen's compensation cases in member hospitals. The schedule applies to all patients in member hospitals on February 1, 1955, or those admitted on or after that date. The schedule which it supplants has been in effect since January 1, 1954.

All elements of cost are included in the inpatient rates which were uniformly developed as part of the annual cost analysis review of hospital expenses for the twelve months ending September 30, 1954. The details of the arrangement with the stock and mutual insurers were completed in cooperation with the National Association of Mutual Casualty Companies, the Association of Casualty and Surety Companies, and the Manufacturers Association of Connecticut.

Tobacco Industry Research Fund Increased to \$1,000,000

The Tobacco Industry Research Committee has increased to \$1,000,000 its fund for independent scientific research into tobacco use and health.

The new allotment of funds will "allow a broad degree of elasticity and adaptability in developing the research program, especially in those fields which the Scientific Advisory Board hopes to expand far more than can be done merely by approving applications as they come in," according to Dr. Clarence C. Little, scientific director and chairman of the Scientific Advisory Board and director of the Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine.

"The additional funds will enable the Board to make great progress in creative planning of additional areas of research which need to be organized and supported and in enlisting those scientists best able to carry out the work in these fields."

Dr. Little said that, in addition to over \$300,000 so far earmarked for specific projects, the Scientific Advisory Board now has under consideration other applications that would greatly increase that total.

Student Nurses

Nearly 1,000 student nurses were admitted to Connecticut's twenty-one state approved schools of professional nursing during 1954, according to the National League for Nursing. The report also observes that throughout the nation more students entered schools of professional and practical nursing during 1954 than in any year since World War II. In the United States and its territories, reported admissions to professional nursing schools disclosed a 3.7 per cent increase over 1953.

Medical Motion Picture Booklet

The Committee on Medical Motion Pictures of the AMA announces that Booklet No. 6 of Reviews of Medical Motion Pictures is now ready for distribution. This booklet contains 64 critical reviews of medical and health films which were published in *The Journal* during 1954. A copy has been sent to the secretary of each State medical society and they are available to county medical societies from the Committee on Medical Motion Pictures. Other requests should be sent to the Order Department, American Medical Association, 535 North Dearborn Street, Chicago 10. The price of individual booklets is 25 cents each or the complete set of six booklets including all reviews published since 1946 is available for \$1.

Salk Vaccine in Venezuela

From *Science* we are informed that Humberto Fernandez-Moran V, director of the Venezuelan Institute for Neurology and Brain Research, Caracas, Venezuela, has announced that his country plans to be the first nation outside of the United States to undertake mass immunization of its citizens with the Salk polio vaccine. Early this spring Fernandez-Moran will institute a pilot study of the vaccine among 2,000 infants in Venezuela to determine the systems and procedures to be used in the mass program. Wyeth Laboratories, which with four other concerns has pioneered in the manufacture of the Salk vaccine upon the invitation of the National Foundation for Infantile Paralysis, will provide the vaccine for the Venezuelan study at no cost.

RECOMMENDATIONS FOR LONG-TERM PATIENTS FROM THE COMMISSION ON CHRONIC ILLNESS

In releasing the following recommendations the Commission on Chronic Illness, which is an independent national agency founded by the American Hospital Association, American Medical Association, American Public Health Association, and the American Public Welfare Association, for the purpose of studying problems of chronic disease, illness and disability, believes that the subject is a timely one. These conclusions and recommendations are based on the experience and knowledge of many people closely associated with the problems of the chronically ill.

GENERAL

1. Care of the chronically ill is inseparable from general medical care. While it presents certain special aspects, it cannot be medically isolated without running serious dangers of deterioration of quality of care and medical stagnation.¹

2. Care and prevention are inseparable; the basic approach to chronic disease must be preventive, and prevention is inherent in adequate care of long-term patients. Persons and institutions assuming care of the long-term patient have an obligation to apply early diagnosis and prompt and comprehensive treatment of the whole patient to prevent or postpone deteriorations and complications which may produce or aggravate disability.

3. Adequate care of the long-term patient requires arrangements which promote frequent evaluation of patient needs and easy flow back and forth among home, hospital, and related institutions.

4. The cost of programs to provide care to long-term patients should be measured first in terms of human values, of effectiveness, and of productivity. The most economical care is that which returns a person as quickly and as fully as possible to the highest attainable state of health and social effectiveness. Practices in conflict with this conclusion must be eradicated and procedures consistent with it substituted.

5. With full appreciation of the necessity for adequate institutional facilities, and realizing that some areas do not have such accommodations and should provide them, the Commission nevertheless feels that henceforth communities generally should

place the greater emphasis on planning for care in and around the home.

6. Rehabilitation is an innate element of adequate care and properly begins with diagnosis. It is applicable alike to persons who may become employable and to those whose only realistic hope may be a higher level of self care. Not only must formal rehabilitation services be supplied as needed, but programs, institutions, and personnel must be aggressively rehabilitation minded.

7. Hospitals, outpatient departments, health departments, nursing organizations, and others furnishing the specialized services required by the long-term patient should reexamine their policies and practices to assure the long-term patient the best of modern medical care. This reorganization should be in the direction of strengthening the personal relationship of physician and patient, bringing the doctor aid and not attempting to substitute the agency for the personal physician.

8. Coordination and integration of services and facilities are so valuable in promoting good care for the chronically ill that all who are concerned with the long-term patient have an obligation to support and further arrangements to this end.

9. No pattern for organizing services is satisfactory for all communities. Programs of necessity must be tailored to fit local situations taking full account of what is good in existing resources for care at home or in an institution. Planning should be based on facts—both local and regional—as to needs, density of population, financial capacity, and types of illnesses and accidents likely to prevail.

10. Planning and programs must be directed to the needs of all long-term patients and not limited to those of any special economic, racial, cultural, or other segment of the population. Planning for all long-term patients must, however, take into account the services now available to special groups such as veteran, fraternal, and others.

11. A significant but unknown number of the 5.3 million persons estimated to be long-term patients are ex-servicemen and women. Of the total service to long-term patients, a considerable proportion is provided by the Veterans Administration. Congress is urged to take necessary action to clarify fully the

federal responsibility to veterans who are long-term patients, and in doing so to be mindful of the community need for integrating programs for care of all long-term patients.

12. Personnel shortages in the professions concerned with the chronically ill remain so serious as to constitute a major block to improvement of care. The number of personnel must be increased by better recruitment, assistance with the costs of education, better salaries, and other inducements to enter and remain in practice. This is particularly applicable to the classes of personnel associated with physicians in patient care.

In addition, changes in curricula for undergraduate, graduate, and postgraduate education are needed to produce personnel interested in and equipped to care for long-term patients.

13. The Commission on Chronic Illness recognizes that the mental illness problem permeates the entire field of care of the long-term patient. An over-all attack on all aspects of the problem is long overdue. The Commission commends the Council of State Governments for its comprehensive 1950 recommendations concerning state mental health programs² and the Governors for the vigor with which they have undertaken to turn the recommendations into action.³ States are urged to continue and accelerate these efforts. The Commission believes that there is great need for continued emphasis on the development of comprehensive community-wide preventive programs in the mental health field.

THE PATIENT AT HOME

1. Most long-term patients can best be cared for at home during much of their illness and prefer care in that setting under supervision of their personal physician. In spite of this, community planning continues to under emphasize such care. Comparatively little effort has been made to organize and provide the means whereby physicians can obtain for their patients the variety of services required to meet the diversified and complex needs that arise in long-term illness.

2. It is imperative that the patient's personal physician participate as continuously as possible in the medical care of each patient at all stages of illness. The physician determines the nature, time, and place for the patient's diagnostic work-up and therapeutic services. The physicians, therefore, must equip themselves with knowledge of new methods of treating long-term illness; learn to use other health professions in care of the patient; and become

familiar with community resources that offer the various services the patient may require.

3. In addition to physician services, long-term care for many patients—though by no means all—requires nursing, dental, social work, nutrition, homemaker, housekeeper, occupational therapy, physical therapy, and other rehabilitative services. In most communities these services, except nursing, are not yet available for the patient in his home. Communities are urged to make these services available and to develop methods to acquaint professional groups and the general public with them.

4. Planning to improve care of the long-term patient at home should be part of a community's general health care program. Such planning must take into account the fact that for some patients care at home may precede, follow, or be interspersed by care in a hospital or other institution.

5. Adequate housing is a fundamental requirement for the care of patients with long-term illness or disability. Community planning for such care must therefore take cognizance of housing needs.

6. The role of the outpatient department in meeting the needs of the chronically ill requires clarification. In most instances a general reorganization of these departments is required to provide the continuity which is so important in the care of the long-term patient. This applies both to departments where the clinic physician temporarily stands in the role of personal physician and those that stand in the role of consultant furnishing special diagnostic and treatment services to amplify the medical care given by the patient's doctor.

The outpatient department must (a) provide services in ways that preserve the dignity and respect the convenience and comfort of the person and which will encourage him to retain a large measure of responsibility for his own health; (b) keep alive the doctor's interest in his patient, and the patient's respect and confidence in his physician; and (c) eliminate fragmentation of patient care into small specialty interests, thus lessening confusion to the patient, the physician, and the entire clinic staff.

Too few outpatient departments have as yet realized the opportunity to provide diagnostic and specialist treatment services needed by practicing physicians for management of selected patients.

7. Home care programs organized to provide auxiliary services to the private physician offer the most effective method yet devised for bringing to long-term patients and their families the coordinated

services required. Up to now they have usually been limited to only a few physicians in a community and for their needy patients. The experience of these programs should be utilized to devise ways to bring integrated auxiliary services to any physician for persons in all economic groups. To be successful, an organized home care program must have these essential characteristics: centralized responsibility for administration; coordination of services and resources; and the development and use of the patient care team to deal with the health needs of the patient.

THE PATIENT IN AN INSTITUTION

ALL INSTITUTIONS CARING FOR LONG-TERM PATIENTS

1. If the long-term patient cannot be satisfactorily treated while residing in his own home, he should be transferred to an institution that affords him the kind of services most appropriate to his current needs. He should not be maintained in a high-cost facility when a less expensive one is available to serve his needs as well or better.

2. A wide range of institutional services is needed. Under current practices these are provided in varying amounts and patterns by the following types of institutions: general, chronic disease, mental and tuberculosis hospitals, special rehabilitation institutions, nursing and convalescent homes and homes for the aged. Many communities cannot afford and are not justified in maintaining all of the personnel and physical facilities involved. For them, the Commission recommends: (a) a drastic rearrangement of functions and relationships of existing institutions; (b) procurement of some needed services on a regional basis; (c) a combination of these procedures.

3. It is incumbent upon all institutions—individually and as a group within the community—to see that their policies and practices regarding long-term patients are carefully framed and meticulously carried out in the interest of the patient. The standards of care for this group must be brought up to that of care given to persons with acute illness. Among the most important areas needing attention are these:

a. Medical supervision. Every institution has a responsibility to insure that all patients have adequate medical supervision, including proper examination at admission and periodic reevaluation. Policies and practices should not preclude maintenance of the patient's personal physician's role in the patient's care.

b. Admission and discharge policies. A hospital should not exclude capriciously or arbitrarily because of diagnosis (terminal cancer, paraplegia, poliomyelitis, tuberculosis, psychosis, etc.) patients who can benefit from the care it offers. However, no institution should admit patients whose essential care requirements it is not prepared to meet. A hospital which cannot meet the requirements of a patient seeking admission should offer assistance to that patient in finding a suitable source of care. No institution should discharge patients in the absence of a care plan designed to permit the patient to maintain his gains and escape exacerbations.

c. Professional and administrative arrangements among institutions. These should be such as to facilitate easy transfer of patients from one to another in accordance with patient needs; and should encourage the greatest possible continuity of care. Cooperative arrangements should extend to community health activities involved in providing care at home.

4. Additional acceptable beds are needed especially for long-term patients who have achieved the fullest benefit from active medical treatment but still need skilled nursing care in an institutional setting.

HOSPITALS

5. The most desirable approach to providing hospital care to long-term patients is through extension, organization, and coordination of the facilities and services of general hospitals both private and public. In some general hospitals this will require only an extension of the hospital's responsibility and re-orientation of the staff so that diagnostic and therapeutic services—disproportionately dedicated to acute illness—will be appropriately and adequately applied to the chronically ill. In many other hospitals additional beds will be needed and personnel, space, and equipment required to provide specialized services to the long-term patient. In all general hospitals the concept, philosophy, and practice of rehabilitation must be paramount.

a. Short-term care of the chronically ill in a general hospital. All general hospitals should devote an appropriate share of their services to long-term patients. The general hospital—of whatever size—which cannot accept responsibility for both short-term and long-term care, should extend to the patient with a chronic disease these services which are likely to be short-term: services for diagnosis and treatment of intercurrent acute illness; evaluation of the need for services not provided by the

general hospital, or better or more economically provided in other types of institutions; and the development of a plan of continued care. The trend of extending psychiatric services in general hospitals, for treatment as well as diagnosis, should be encouraged.

b. Long-term care in a general hospital. General hospitals should provide adequate units and services for patients requiring prolonged periods of care.

The large general hospital is urged to equip itself with the full range of facilities, both for the patients needing skilled nursing service and rehabilitation, and units for those needing less skilled care. A chronic disease unit offering primarily skilled nursing service and physical medicine is recommended for the large general hospitals.

The small general hospital that cannot provide, through its own resources, the full scale of services is urged to make arrangements on a regional basis for services to be available at the small hospital.

6. The independent chronic disease hospital is a second choice approach to long-term hospital care. It should be considered only when there is no practical way to associate the chronic disease facility physically and administratively with the general hospital. Where a special chronic disease hospital is unable to affiliate itself with a general hospital, it must have adequate facilities and personnel for thorough diagnostic work-up, intensive study of the patient, and a dynamic program for definitive medical care and rehabilitation. The construction of new independent chronic disease hospitals (except research institutions) is not recommended.

8. Progress in control of a number of the more serious chronic diseases depends upon research which can be conducted best where substantial numbers of patients can be observed over a long period of time. Chronic disease hospitals and chronic disease units of general hospitals have a unique opportunity to conduct such investigations and should include research among their principal functions.

8. The long-term patient belongs in private general hospitals as well as in tax-supported general hospitals—a combination of voluntary and public effort is applicable to the care of the long-term patient as it is to the care of the acutely ill patient.

MENTAL INSTITUTIONS

9. Every state should survey periodically its men-

tal institutions and plan systematically for improving its services and facilities.

10. The hospitalized mentally ill constitute a major chronic disease problem for the nation and merit a comprehensive research effort.

11. Every mental hospital should have an adequate therapeutic program, the primary goal of which is rehabilitation of the patient and prompt restoration to community life as soon as the need for social restraint is over. A second goal is to improve the lot of the patient who has to remain in the hospital for a prolonged period.

Restoration to community life which is the aim of rehabilitation in the mental hospital demands a close integration with the community resources available to the patient.

12. Not all mental patients needing institutional care require care in a special mental institution. For many of these patients the general hospital offering psychiatric services represents the appropriate source of care.

13. Long-term mental patients, both those who present merely the mild confusions so often found among the elderly, and the patient whose psychosis has burned itself out, can be adequately cared for in a carefully selected custodial setting in public or private nursing homes. The stigma attached to the commitment to mental hospitals can be avoided. Experiments are under way to determine how best to care for these inactive or subclinical mental patients.

NURSING HOMES AND RELATED INSTITUTIONS

14. Nursing homes and related institutions are essential for some phases of long-term illness. They are presently being operated under a variety of auspices—public; proprietary; and nonprofit voluntary such as religious and fraternal and in some instances hospital. Though there are many that are rendering excellent service, too many are operating unsatisfactorily.

Simultaneously and concurrently many of these institutions must yet equip themselves to provide safe and adequate care and become properly aligned with other community resources serving the chronically ill. Only when this is accomplished can they fulfill their role acceptably and solve the problem of many long-term patients who otherwise must resort to inappropriate—and probably more expensive—care.

Individual physicians, medical societies, and hospital staffs particularly are urged to recognize the nature of the contribution which care in nursing and convalescent homes and homes for the aged can make and to help bring about the necessary reforms.

15. On the basis of its studies and analysis of the problems, the Commission believes that development of these institutions as elements of general hospitals is one of the best ways of raising standards, and recommends this arrangement. When outright affiliation is impossible, a close and active working relationship should be maintained.

16. Standards of medical, nursing, and personal care in many of these institutions are not acceptable and must be raised. Two major factors are involved: (a) knowledge of what to do and how to do it; (b) better financing.

a. Knowledge of what to do and how to do it. The Commission on Chronic Illness endorses and commends the nursing home standards recommended by the National Social Welfare Assembly's Committee on Aging in 1953, and the suggested procedures for establishing and maintaining them.⁴

Through educational programs and proper exercise of their jurisdiction, licensing and standard-setting authorities can effect great improvements in physical facilities and care in nursing homes and related institutions. Recent legislation⁵ and the knowledge resulting from recent studies of patients and institutions have produced an unprecedented opportunity for progress in this field. Licensing and standard-setting authorities are urged to move vigorously to take advantage of this auspicious situation.

b. Better financing. Financing is probably the most neglected and unresolved area in improving care in the bulk of nonhospital institutions. The efforts of licensing authorities and nursing home operators to apply new knowledge and otherwise raise standards can succeed only if better financial support is forthcoming for these institutions, particularly the ones that are financed largely through public assistance. To provide a sounder financial basis for nonhospital institutions and the improvement of their standards, the Commission recommends that:

Private insurance and prepaid medical and hospital plans extend the scope of benefits offered to include this type of service.

Philanthropic agencies—national voluntary organizations devoted to specific disease categories, community chest, united funds, religious and fraternal

groups, for example—consider this type of service as a need that deserves support commensurate with other types of care.

Responsible authorities make sufficient funds available to enable public agencies operating such facilities or purchasing this type of care to expend sufficient amounts to assure the quality of care required.

Tax funds be sufficient to support a program of inspection, licensing, education, and supervision.

REFERENCES

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2. "The Mental Health Programs of the Forty-Eight States." *The Council of State Governments*, Chicago, Illinois. 1950.
3. *Governors' Conference on Mental Health*. State Government, March 1954.
4. *Standards of Care for Older People in Institutions: Section I, Suggested Standards for Homes for the Aged and Nursing Homes; Section II, Methods of Establishing and Maintaining Standards in Homes for the Aged and Nursing Homes; Section III, Bridging the Gap Between Existing Practices and Desirable Goals in Homes for the Aged and Nursing Homes*. Published by the National Committee on the Aging of the National Social Welfare Assembly under a grant from the Frederick and Amelia Schimper Foundation, 1953, 1954.
5. 1954 Amendments to Hospital Survey and Construction Act (Public Law No. 482, 83rd Congress) and 1950 Amendments to Social Security Act (Public Law No. 734, 81st Congress) relating to licensing and standard-setting in nursing homes.

Should Your Child Be a Nurse?

A new booklet, designed to interpret professional nursing as a career especially to parents of teen-agers, is announced by the Committee on Careers, National League for Nursing, which spearheads recruitment of students for nursing nationally. The booklet, entitled "Should Your Child Be a Nurse?", has been donated to nurse recruitment by the New York Life Insurance Company.

Copies of the nursing booklet are being made available without charge by New York Life to nurse recruitment committees, nursing schools, hospitals and health agencies throughout the country for distribution to teen-agers and their parents. Anyone interested in having a copy should write the New York Life Insurance Company, Department JCP, 51 Madison Avenue, New York 10, N. Y.

Connecticut Committee on Foods, Drugs, Cosmetics and Devices Meeting of December 2, 1954

The member societies and institutions were represented at this meeting as follows: Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut Pharmaceutical Association, Prof. Nicholas W. Fenney; Connecticut State Dental Association, Dr. William Kirschner; Connecticut State Medical Society, Dr. Hugh Dwyer; Connecticut Veterinary Medical Association, Dr. Joseph DeVita and President Vincent J. Peppe; University of Connecticut, Dr. Stanley E. Wedberg; University of Connecticut College of Pharmacy, Dean Harold Hewitt; Yale University School of Medicine, Dr. Desmond D. Bonnycastle.

The following were also present: Dr. Felix Blanc, representing the Pharmacy Commission; Dr. Barnett Greenhouse, representing the Joint Committee of the State Medical Society and the Pharmaceutical Association; Drs. James C. Hart and J. Howard Johnston, representing the State Department of Health; Mr. Herbert Plank, representing the Food and Drug Commission.

ANTIDOTES

Dr. Bonnycastle reported that there were two possible ways of handling the antidote question: (1) to have a key reference to potential antidotes opposite each product listed (in which case Dr. Plessen should write up detailed descriptions of standard procedures); and (2) to confine the list to brand names and ingredients and refer to Dr. Press's handbook for treatments. Dr. Bonnycastle showed the list he had prepared to date. Dr. Johnston said that at the conference on September 14 it had been suggested that he write the Patent Office for a list; he had done this, and had received a reply that applications for trademarks did not reveal the composition of the trademarked products. He had also written for a copy of the New York law, which he had with him. Prof. Fenney asked Dr. Johnston if he thought the New York law was of value; he replied that he thought it definitely was.

Dr. Bonnycastle asked if a list of antidotes might be valuable of itself; the New York law did not require antidotes to be stated but only recommended that they be carried on labels—and the treatment on labels was not likely to be advanced enough.

On motion of Dr. Wedberg, seconded by Prof. Fenney, it was voted that steps be initiated to publish and disseminate through the proper State agencies our present list with addition of such other material as might be available.

On motion of Prof. Fenney, seconded by Dr. Hewitt, it was voted that an attempt be made by the Committee to stimulate the proper State agency to take steps to pass a law something like the New York law.

THE SALE OF DENTAL PLATE RELINERS IN RETAIL PHARMACIES

Dr. Kirschner began his report on this subject by stating that he had suffered a very sore mouth from trying out the Brimm's Plasti-Liner. He displayed a denture with some of the material on it, and remarked that the "Plasti-Liner" did get hard without being worn even though the accompanying literature said it did not. He had applied the material to a plastic denture and kept it under water for six weeks. A denture must be cleaned and dried before the soft plastic material is applied to it. He had received a letter from George C. Paffenbarger, D.D.S., senior research associate of the American Dental Association at the National Bureau of Standards, to the effect that "Brimm's Plasti-Liner . . . does harm the denture made of acrylic resin."

Dr. Kirschner remarked that obviously a 36 per cent decrease in strength was not visible but was serious; the claim in the Brimm's circular that "It will not harm plates or irritate gums" was false advertising. He added that this was not an orthodox procedure for correcting faults in a denture; a trained person was needed to make such corrections.

On motion of Fisher, seconded by Bonnycastle, it was voted that it be the opinion of the Committee that the "Brimm Plasti-Liner" was harmful and falsely advertised.

Dr. Greenhouse said he thought this material would be discarded long before damage to tissues occurred, to which Dr. DeVita replied that a person in low economic circumstances would keep on using the reliner to avoid the expense of a new denture. Dr. Kirschner added that some people's tissues break down much faster than those of others—some people had to have their dentures corrected two or three times a year. To a question of Dr. Hart as to whether in such circumstances a new plate was made, Dr. Kirschner said: "No, the plate was relined."

(The manufacturer of "Brimm's Plasti-Liner" is Plasti-Liner Co., Inc., 1740 Bailey Avenue, Buffalo 11, N. Y.)

THE SAFETY OF BARLEY SUGAR LOLLIPOPS AS

REGARDS DENTAL DECAY

On this subject Dr. Kirschner read a letter of Sholom Pearlman, D.D.S., assistant secretary of the Council of Dental Therapeutics of the American Dental Association. He remarked that as far as was known the nature of a sugar did not matter as far as its action on caries was concerned so long as the sugar was fermentable, although sorbitol (which was not actually a sugar) was reportedly fermented at a low rate. He had been unable to get a sample of the lollipops in question.

Dr. Greenhouse remarked that the National Research Council had appointed a committee to study the physiological effects of sorbitol and similar compounds.

On motion of Fisher it was voted that in the light of Dr. Kirschner's report it be the opinion of the Committee that the lollipops were not completely safe as regards causing dental decay; it was also agreed that Mr. Cole be asked to furnish samples and literature.

"KURVON"

A circular for a product of this name had been received from Mr. Plank on October 19. This circular (put out by World Wide Pharmacal Distributing Co., 505 North La Salle Street, Chicago 10, Illinois) described "Kurvon" as "a pure herb preparation . . . today being prescribed by physicians to increase the size of small or sagging mammary glands." The active ingredient was stated to be "Extract of Galega, made from a plant which grows naturally in the south of France and in the Mediterranean area," which contained an alkaloid "galegine." The action of "Kurvon" was explained as follows:

"The reason Kurvon succeeds is simple. Most women with flat or sagging breasts lack mainly well developed milk glands and fat tissues in the breasts. The Galega herb in Kurvon has long been used by physicians to stimulate the mammary glands and thus induce firmer, fuller breasts with resulting appeal and beauty of the female form."

Without much discussion the Committee voted, on motion of Dwyer seconded by Wedberg, that in its opinion such a product could not be effective.

LAWS TO CONTROL THE SALE OF "VETERINARY
USE" DRUGS

Dr. DeVita said that on a trip to Colorado he

had told of our discussions of this subject and the suggestions that had been made as to dyeing mastitis injections, etc. The Colorado people had been very interested, and had later informed him that the Governor of Colorado had appointed a committee to look into the subject and recommend legislation for that State.

Dr. Howlett Named Superintendent at Laurel Heights Sanatorium

Dr. Kirby S. Howlett, Jr., was recently named superintendent and medical director of Laurel Heights Sanatorium to succeed Dr. Edward J. Lynch, who retired last December. In announcing the appointment, the State Tuberculosis Commission also stated that Dr. Howlett will be succeeded in his previous position of assistant superintendent by Dr. Frederick C. Warring.

Dr. Howlett joined the medical staff at Laurel Heights in 1935 and assumed his duties as assistant superintendent in 1943. He previously had served as an intern and assistant resident physician at Trudeau Sanitarium, 1931 to 1934, and as a resident physician at the Tuberculosis Unit, University of Michigan Hospital, 1934-35.

A native of Franklin, Tennessee, Dr. Howlett is a graduate of the United States Naval Academy. He received his master's degree in science at Vanderbilt University in 1927 and his medical degree at Vanderbilt University School of Medicine in 1931. He has served as president of the American Trudeau Society and is currently chairman of the Society's Nominating Committee. A member of local, state and national medical associations, Dr. Howlett is also a member of the Editorial Board of the American Board of Tuberculosis Review. He is an associate clinical professor of medicine, Yale University School of Medicine.

Dr. Warring is a native of Baltimore and a graduate of Johns Hopkins University and its medical school. He was a member of the medical staff at Trudeau Sanitarium and at the Maryland State Tuberculosis Sanatorium prior to coming to Laurel Heights in 1936. He has been clinical director of the sanatorium since 1951 and is an assistant professor of medicine, Yale School of Medicine.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Newell W. Giles, Darien

President-Elect, Mrs. Norman J. Barker, Collinsville

First Vice-President, Mrs. J. ALFRED WILSON, Meriden

Second Vice-President, Mrs. Frank L. Polito, Torrington

Recording Secretary, Mrs. Charles Culotta, Hamden

Corresponding Secretary, Mrs. C. Murray Gratz, Cos Cob

Treasurer, Mrs. Joseph Woodward, New London

Public Relations

Mrs. John Bucciarelli, chairman of Public Relations, has received a second request for permission to copy the "First-Aid" chart, this time by the Cincinnati Academy of Medicine.

She has made arrangements with the Stamford radio station for the second series of educational recordings, to begin April 12. Called "Sixteen," it is a follow-up series for teenagers.

Legislation

The Auxiliary's chairman, Mrs. Gardner Russell, wants to inform the membership about the State Medical Society's policies regarding legislation. The State Legislative Committee takes a stand on proposed legislation because a proposed bill:

1. Affects the present method of the practice of medicine or the allied professions.
2. Affects the quality and standards of medical and related professions who shall be eligible to care for patients.
3. Affects hospitals and other similar institutions in which doctors work.
4. Affects the broad programs of public health.
5. Affects new institution's programs and plans that may make better medical, nursing, dental and related services more available to the people of this State.
6. Affects the professional training program in the field of medical, dental and nursing fields.
7. May require technical experts in the field of medicine and the related sciences for its interpretation.
8. May invite an overall planning operation involving medicine, welfare and broad social services.

The Legislative Committee will not be expected to make recommendations where:

1. Only administrative changes are involved in accepted programs.

2. Decisions of allocation of available funds in the overall State budget is concerned.

3. The question of whether accepted medical and scientific standards and practices should be applied to certain legal procedures.

Membership

State Auxiliary membership has reached a new high of 1,209, an increase of 134 members over the previous year of 1953-54. This means we have exceeded our 10 per cent quota as set by National by 17 members. Fairfield and Middlesex Counties have already reported five new members each for 1955.

Annual Meeting

On April 27 the Annual Meeting will be held in Bridgeport at the Brooklawn Country Club.

The following recommendation was passed by the State Board of Directors at its January meeting and Mrs. James Gold moved that a recommendation be presented at the Annual Meeting to have a similar resolution adopted and sent from the entire membership:

WHEREAS, Mrs. Robert Flanders of New Hampshire has efficiently and loyally served the Woman's Auxiliary to the American Medical Association as First Vice President, member of the Board of Directors, Chairman of the Revisions Committee, Fourth Vice President, and Chairman of Organization for the Eastern Region; and

WHEREAS, Mrs. Robert Flanders has been President of both State and County Woman's Auxiliary to the New Hampshire State Medical Society and was one of its organizers; and

WHEREAS, Mrs. Robert Flanders is eminently qualified in ability, experience and tact as well as in warmth and graciousness of personality; and

WHEREAS, A president of the Woman's Auxiliary to the American Medical Association has never been selected from the New England States; therefore, be it

RESOLVED, That the Board of Directors of the Woman's Auxiliary to the Connecticut State Medical Society assem-

bled this day, January 17, 1955 in New Haven go on record as requesting the Nominating Committee of the Woman's Auxiliary to the American Medical Association to select for the office of President-Elect of the Woman's Auxiliary to the American Medical Association the name of Mrs. Robert Flanders of New Hampshire.

County News

FAIRFIELD

Mrs. Giles was the guest of the Auxiliary at its February Board Meeting which met at Manero's in Westport. The chairman of Legislation brought attention to bills in the State legislature concerning guardianship of neglected and uncared for children. After contacting Dr. Barker letters were written to the Governor and legislators on the Public Welfare and Humane Institution Committee approving the principles set forth and expressing our support of the measures in HB343 introduced by Mrs. Paul Vestal.

A Nursing Scholarship of \$350 will be awarded after April 1.

HARTFORD

In March the Committee on Mental Health, Mrs. Francis Braceland, chairman, held a meeting for members of the Auxiliary. Dr. John Nurnberger, educational director of the Institute of Living, spoke on "Contributions of Research to Mental Health—a View to the Future."

At the Legislative meeting last month, under the chairmanship of Mrs. Irving Krall, Mrs. Paul Vestal discussed bills in the health and welfare fields coming before the State Legislature.

The annual meeting was held April 5 at Wampanoag Country Club. Dr. Vernon Lippard, dean, Yale School of Medicine, spoke on "Current Problems in Medical Education." A fifteen minute film on Civilian Defense was shown.

LITCHFIELD

The annual meeting is to be held at Mt. View Inn, Norfolk, with Dr. Atchley of the Salisbury Health Center as speaker.

A committee headed by Mrs. Garston of Torrington is planning a clam bake outing at Highland Lake, Winsted on June 29. This will be a tenth anniversary celebration and is intended for all physicians and their wives in Litchfield County. It will be an earnest attempt to encourage a larger member-

ship and to stimulate more interest on the part of the County Medical Association in its Auxiliary.

MIDDLESEX

Mr. Merle W. Mudd, director of education, Connecticut Association for Mental Health, spoke on "Mental Health—a Challenge and an Opportunity," at the March meeting.

The annual meeting will be held April 14 at Restland Farms, Northford at 4:30 P. M., followed by dinner as guests of the Middlesex County Medical Association.

The AMEF Fund in this county now has reached \$105.

Middlesex County Auxiliary is a member of the *Today's Health* 1955 Exclusive Club. As of January 1955, it was 15th nationally in Group III auxiliaries. Gifts of one year subscriptions to *Today's Health* have been given to Middlesex Memorial Hospital, Connecticut State Hospital and the Y. M. C. A. in Middletown.

NEW HAVEN

Mrs. Charles Umba of the Occupational Therapy Department, Connecticut State Hospital, Middletown, was speaker at the spring meeting.

On April 7 there will be a Silver Tea for the benefit of the AMEF at the Lounge of the Sterling Hall of Medicine in New Haven. Mrs. Orvan Hess is chairman. The women who will pour are Mesdames Newell Giles, Edward Allen, Theodore Evans, Vernon Lippard, Lewis Beardsley, Richard Lee, and Creighton Barker.

The annual meeting will be held on April 14. Mr. Charles Leonard, superintendent of the Child Study Home will speak on "The Development and Program of the Child Study Home."

NEW LONDON

In response to a request from the William W. Backus Hospital School of Nursing for a 1955 student nurse scholarship, the board voted to send \$300 to Miss Gurski, director of nurses.

The annual meeting will be held April 19 at Lighthouse Inn. Mr. Donald Shepard, librarian at the Submarine Base, Groton, will be the guest speaker. His topic will be "The Nautilus." Mrs. Julian Ely is in charge of the program. Handicrafts from several booths manned by doctors' wives for the William W. Backus Hospital Gypsy Fair will be displayed.

SPECIAL NOTICES

ST. FRANCIS HOSPITAL SEIZURE CLINIC

The Seizure Clinic of St. Francis Hospital, Hartford, Connecticut, is offering physicians of the State an opportunity for training in the diagnosis and management of epilepsy. A maximum of two physicians at a time will be appointed for periods of six months.

The Seizure Clinic of St. Francis Hospital was established in 1953 in cooperation with the Connecticut State Department of Health. The Clinic meets each Saturday morning and currently carries a case load of 100 patients. It is conducted by Doctor Wladimir T. Liberson under the supervision of the Department of Neuropsychiatry and Neurosurgery of St. Francis Hospital.

For more detailed information interested physicians should write to Dr. Wladimir T. Liberson, St. Francis Hospital, 114 Woodland Street, Hartford, Connecticut.

HARTFORD HOSPITAL GUEST SPEAKER PROGRAM

Saturdays, 11 A. M., Amphitheater
March 26, 1955 to June 16, 1955

March 26

Benjamin Spector, M.D., professor of anatomy, Tufts College Medical School

The Bio-Anatomy of Back Pain

April 2

Leon Whitney, M.D., chief of the Whitney Clinic, Orange, Conn.

Epizootic Disorders—Blame Your Pet or Yourself?

April 9

Nicholas D'Esopo, M.D., chief physician, Tbc unit, West Haven Veterans Administration Hospital, associate clinical professor of medicine, Yale University School of Medicine

The Future of Tbc for the Internist

April 16

J. Robert Wilson, M.D., professor of obstetrics and gynecology, Temple University School of Medicine

10 A. M.—Edema in Pregnancy

11 A. M.—Pudendal Block Anesthesia

April 23

Motion Picture of Television Symposium, "Streptococcus Infection and Its Complications," American College of Physicians

April 30

Houck E. Bolton, M.D., Hahnemann Medical School and Hospital

The Surgical Treatment of Aortic Stenosis

May 7

Philip M. Stimpson, M.D., associate professor of clinical pediatrics, Cornell University

Recent Development in Poliomyelitis

May 14

Levin Waters, M.D., associate professor of pathology, Yale University School of Medicine

The Pathology of Arteriosclerosis

May 21

Fiorindo A. Simeone, M.D., professor of surgery, Western Reserve University

The Study and Treatment of Peripheral Arterial Disease

May 28

Professor J. A. V. Butler, professor of chemistry, University of London

Radiation Research

June 4

S. J. Thannhauser, M.D., professor of medicine, emeritus, Tufts College Medical School

Case Presentations

June 11

Franklin Hutchinson, M.D., PH.D., assistant professor of radiation physics, Yale University School of Medicine

The "H" Bomb and the Doctor

June 16

Thursday—Alumni Day. Program pending

REGIONAL MEETING OF THE AMERICAN COLLEGE OF GASTROENTEROLOGY

A regional meeting of the Southern Region of the American College of Gastroenterology will be held in Memphis, Tenn., on Sunday afternoon, April 24, 1955. The Scientific Session will be held in The Skyway, at the Hotel Peabody, commencing at 2:00 P. M., and following the semi-annual meeting of the Board of Trustees of the College.

Members of the medical profession are cordially invited to attend. A copy of the program may be obtained from the Secretary, American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

ASSOCIATION OF TUMOR CLINICS

The Spring Meeting of the Connecticut Association of Tumor Clinics will be held at the Norwalk Hospital on Thursday, May 5 at 4 P. M. The speakers will be Harold W. Dargeon, attending pediatrician, Memorial Hospital, who will speak on "Cancer in Children"; and Emerson Day, director, Strang Prevention Clinic, Memorial Hospital, who

will speak on "Detection of Early Cancer in Office Practice."

MENTAL HEALTH CONGRESS

On May 13, probably in co-sponsorship with one of the Connecticut professional psychiatric groups, the 1955 Mental Health Congress will be held in the Capitol Ballroom of the Hotel Statler in Hartford. The Congress will consist of afternoon sessions of a popular nature and a dinner session in the evening, both of which will feature outstanding speakers from the field of mental health.

AMERICAN ASSOCIATION OF THE HISTORY OF MEDICINE

Annual Meeting—1955—Detroit, Michigan. Thursday, Friday and Saturday, May 12, 13 and 14. Headquarters: The Park Shelton Hotel.

TRUDEAU SCHOOL OF TUBERCULOSIS FOR 1955

Forty-first Annual Session

Despite the closing of the clinical facilities of the Trudeau Sanatorium, the forty-first session of the Trudeau School of Tuberculosis will begin Wednesday, June 1 and continue to June 29.

The staff, facilities and skills of the Trudeau organization laboratories, of the various sanatoria in the Saranac Lake area, and of the practising tuberculosis specialists of Saranac Lake will be called upon as in the past to present the program.

The course will cover all aspects of pulmonary tuberculosis and also certain phases of other chronic chest diseases, including those of occupational origin.

The schedule for the 1955 course is in preparation but copies of the program for 1954 are available.

Registrations will be limited and it is suggested that those planning to attend make early application for enrollment.

The tuition is \$100, payable to the Trudeau School on or before the opening date, June 1, 1955. A few scholarships are available for those individuals who can qualify.

The Trudeau School of Tuberculosis has been approved for training of veterans under Public Laws and any applicant desiring to obtain veteran's benefits should clear his registration with the Veterans Administration before the session begins.

Applications and more detailed information may be obtained from: Secretary, Trudeau School of Tuberculosis, Box 200, Trudeau, New York.

AMERICAN SOCIETY FOR THE STUDY OF STERILITY JUNE 3-5, 1955
Ritz-Carlton Hotel, Atlantic City, N. J.

TUBERCULOSIS SYMPOSIUM

The fourth annual Symposium for General Practitioners on Tuberculosis and other Chronic Pulmonary Disease will be held in Saranac Lake, New York from July 11 to 15, 1955. It is approved for 26 hours of formal credit for members of American Academy of General Practice.

This five day course is designed particularly for General Practitioners and presented over a period short enough so that they may readily attend. Many of the sessions are informal panel discussions with ample opportunity for questions from the audience.

Sessions will be held in the various sanatoria, hospitals and laboratories in the Saranac Lake area. The faculty will consist of physicians, surgeons and scientists from Saranac Lake as well as guest lecturers.

Many doctors attending previous sessions of this Symposium have brought their families with them to enjoy the many vacation facilities of the surrounding Adirondack Mountains. So that families may have the use of the family car, free bus transportation will be provided to the various meeting places for the doctors attending the course. Excellent housing accommodations are available in and around Saranac Lake.

The registration fee for the Symposium is \$40. Further information and copies of the program can be obtained by writing Dr. Richard P. Bellaire, General Chairman, Symposium for General Practitioners, P. O. Box 2, Saranac Lake, N. Y.

ANNOUNCING 8th ANNUAL MEETING
AMERICAN ASSOCIATION OF BLOOD BANKS
Palmer House, Chicago, Illinois,
November 19-20-21, 1955

Excellent scientific program. Interesting exhibits. Refresher course for technologists. Roundtable and panel discussions led by national and international authorities. Plan now to attend.

For further information write American Association of Blood Banks, 725 Doctors Building, 3707 Gaston Avenue, Dallas 10, Texas.

THE DOCTOR'S OFFICE

Benjamin Allen, M.D. announces the opening of an office for the practice of otolaryngology and plastic surgery of the face at 117 East State Street, Westport.

Robert C. Doherty, M.D. announces the opening of an office for the practice of psychiatry at 50 Farmington Avenue, Hartford.

Additional List of Health and Welfare Bills in the Connecticut General Assembly

House

HB1257—Making an Appropriation for Financial Assistance for Training in Child Psychiatry makes an appropriation for financial assistance for training in child psychiatry.

HB1401—The Duties of School Medical Advisers to be consistent with the proposed revision of section 1464 wherein the responsibility for supervising the sanitation of the school cafeteria is placed with the local director of health.

HB1447—Sales Tax—Exemptions. Identical with SB333.

HB1564—Detention of Mentally Ill Persons Prior to Commitment. Identical with SB935.

HB1579—Disposition of Insane Person Upon Expiration of Term substitutes probate court commitments in place of orders for further confinement procured by the state's attorney.

HB1580—The Examination of Accused Who Appears to be Insane provides for the emergency commitment of an accused to a state mental institution.

HB1582—Narcotics. Identical with SB38.

HB1623—Report of Persons Subject to Epileptic Attacks eliminates discriminatory provisions against epileptic individuals.

H1635—Amending the Workmen's Compensation Act to Provide for Free Choice of Physician. Identical with SB 878.

HB1636—Amending the Workmen's Compensation Act to Provide for Back Injuries provides for compensation for partial incapacity resulting from back injuries.

HB1652—Compensation for Second Injury includes persons afflicted with epilepsy under the protection of the second injury provision of the Workmen's Compensation Act in order to eliminate one of the major bars to their employment.

HB1686—Requiring Blood Types to be Stated on Operators' Licenses requires blood types to be stated on operators' licenses.

HB1689—Abstracts of Operating Records Furnished by the Commissioner of Motor Vehicles allows a reasonable length of time to the commissioner of motor vehicles to prepare abstracts of operating records.

HB1712—Rewording of the Food and Drug Statutes changes the wording of the general statutes so as to give effect to the creation of a new department of Consumer Protection.

HB1713—The Repeal of Certain Food and Drug Statutes effectuates the removal of the new department of Consumer Protection from the area of control over the dispensing of alcoholic beverages.

HB1723—The Labeling of Hazardous Substances. Identical with SB901.

HB1725—Notice to the Public of Use of Fluoridated Water. Identical with SB902.

HB1726—Notice of the Addition of Fluoride to Public Water Supplies. Identical with SB903.

HB1731—Authorizing the State to Participate in the Establishment of Community Outpatient Psychiatric Clinics authorizes the state department of health and the state department of mental health to jointly participate in the establishment of community psychiatric clinics, to provide essential and vital services to individuals in the community and those who have been in state institutions.

HB1770—Medical Treatment for Persons Liable for Town Support prevents billing by hospitals and physicians when towns have insufficient knowledge of persons involved.

HB1771—Norwich State Hospital provides separate accommodations at said hospital for inebriates.

HB1774—Providing for a Terminal Bed Hospital to found an institution known as a terminal bed hospital where therapy may be rendered to cases of incurable cancer.

HB1775—A Commission for Problems of Aged Citizens. Identical with SB429.

HB1778—Authorizing Non-Tuberculous Patients to be Treated in State Sanatoria allows non-tuberculous patients to be treated in state sanatoria when space is available.

HB1824—Governing Hospitalization of the Mentally Ill governs hospitalization of the mentally ill.

HB1837—Refusal of Medical Service by a Workmen's Compensation Complainant.

HB1840—Operation of Motor Vehicles While Under Influence of Intoxicating Liquors or Drugs.

Senate

SB778—Tax Exemptions of State-Supported Hospitals and Sanatoria allows tax exemption for property of hospitals and sanatoria receiving state-aid subsequent to May 1, 1953.

SB810—Payment of Hospitalization Insurance Premiums by the State.

SB836—Qualifications for Chiropody License Without Examination permits endorsement of other state licenses only when such other states extend like privileges to Connecticut licensed chiropodists.

SB869—Unemployment Compensation—Disqualifications: Pregnancy and Childbirth eliminates the provision disqualifying women who have returned to the labor market after leaving their employment for childbirth and who are available for work, able of work, and actively seeking work.

SB878—Amending the Workmen's Compensation Act to Provide for Free Choice of Physician enables an injured employee to choose his own physician.

SB887—Workmen's Compensation — Notice of Injury. Identical with HB1088.

SB899—Issuing a Motor Vehicle Driver's License to Persons Suffering from Epilepsy and Related Conditions gives the commissioner of motor vehicles authority to issue a motor vehicle driver's license to certain persons suffering from episodic impairment of consciousness or loss of motor control when it is in the interest of public safety to do so; and to set up a medical advisory board to assist the commissioner of motor vehicles in making his decisions.

SB901—The Labeling of Hazardous Substances protects the public health by supplying to physicians and others information on the composition of materials sold under unrevealing brand names, in order that the knowledge of the identity of hazardous ingredients that is necessary for prescribing proper treatment in cases of accidental swallowing or other contact may be instantly available.

SB902—Notice to the Public of Use of Fluoridated Water provides for posting of fluoridated water.

SB903—Notice of the Addition of Fluoride to Public Water Supplies requires notice of the addition of fluoride to public water supplies.

SB904—Preventing the Use of Public Water Supplies as a Vehicle for Medication provides that fluoridating public water supplies is a criminal offense.

SB905—Payments to Hospitals by the State and by Municipalities permits the state and the various municipalities to operate on fiscal years of their own choosing without undue hardship to the state, the municipalities or the hospitals.

SB929—Commitments to Mansfield State Training School and Hospital provides for commitment to Mansfield in the same manner as SB931 provides for Southbury.

SB931—Commitments to Southbury Training School provides mandatory commitment of feeble-minded and epileptic persons and relieve the towns of responsibility of placement in private institutions, and transfer the expense of support to the state institution if such private placement must be continued after such commitment.

SB932—Exemption of Property Held by Non-Profit Hospitals and Sanatoriums From Taxation establishes tax exemptions for hospitals or sanatoriums on the basis of their being non-profit institutions rather than on the fact that they once received state aid. (Institute of Living, Hartford)

SB933—Authorizing Non-Tuberculous Patients to be Treated in State Sanatoria. Identical with HB1778.

SB934—Detention Prior to Commitment for Mentally Ill Persons places full responsibility in the hands of the commissioner of mental health for commitment and not leave the individual at the mercy of relatives or physicians retained by such relatives.

SB935—Detention Prior to Commitment of Mental Patients gives proper effect to the action of the Probate Court.

SB1045—Relative to the Solicitation of Funds for Charitable Purposes transfers solicitation of funds from welfare commission to the attorney general and to provide safeguard against misrepresentation.

SB1060—Liens on Proceeds of Accident and Liability Insurance Policies in Favor of Hospitals provides for venue of action and service of process.

SB1076—Professional Fund Raising requires the licensing of professional fund raisers and to require they perform their services for a set fee rather than on a percentage basis.

SB1097—Authorizing Selection of Physician by Injured Workmen permits the injured worker to select his own physician and to protect the rights of all parties affected by such selection.

SB1099—Compensation For Time Lost While Receiving Medical Treatment. Identical with HB1135.

SB1119—Examination for Drinking Drivers on the Highways provides for chemical test to determine alcoholic content of the blood in cases of automobile drivers allegedly intoxicated.

SB1142—Admission to and Support in Tuberculosis Sanatoria provides for payment of costs in tuberculosis sanatoria by the state.

SB1145—Patients in State Tuberculosis Sanatoria makes the cost of care, support and treatment of tuberculosis patients the obligation of the state, but permitting voluntary payments to be made therefor.

SB1181—Definition of Practice of Chiropractic.

SB1182—Examination for License to Practice Chiropractic.

Foreign Medical Meetings

Physicians planning trips abroad during the coming months may wish to attend these and other scientific meetings in the country they visit. The list given herewith was provided by the World Medical Association.

APRIL

24-29—Washington, D. C.

5th Inter-American Congress of Radiology

Office of the Secretary-General, 3400 Spruce Street, Philadelphia 4, Pennsylvania

28-30—London

Ophthalmological Society of the U. K.—Annual Meeting
The Society, 45, Lincoln's Inn Fields, London, W.C.2.

30-May 1—Lugano

Séance scientifique de la Société des médecins suisses spécialisés en tuberculose et de l'Association suisse contre la tuberculose

Dr. H. Egli, Fédération des Médecins Suisses, Sonnenbergstrasse 9, Berne

Japan

The 13th General Assembly of All Japan Medical Societies

MAY

- 5-7—Cheltenham, England
Medical Women's Federation—Meeting
Miss M. Rew, Medical Women's Federation, Tavistock House, North, Tavistock Square, London, W.C. 1
- 5-7—Paris
British Orthopaedic Association—Spring Meeting
The Association, 45, Lincoln's Inn Fields, London, W.C.2
- 7-8—Genève
Assemblée annuelle de la Société suisse de médecine interne
Dr. H. Egli, Fédération de Médecins Suisses, Sonnenbergstrasse 9, Berne
- 8-12—Paris
62nd Congress of the French Society of Ophthalmology
Dr. Marcel Kalt, 81 rue Saint-Lazare, Paris 8e.
- 10—Mexico
8th World Health Assembly (WHO)
World Health Organization, Palais des Nations, Geneva, Switzerland
- 12-14—London
Institute of Hospital Administrators—Annual General Meeting
The Secretary, Institute of Hospital Administrators, 75, Portland Place, London, W.1
- 13-15—Baden
Assemblée annuelle de la Société suisse de chirurgie
Dr. H. Egli, Fédération des Médecins Suisses, Sonnenbergstrasse 9, Berne
- 19-22—Albi, France
28e Congrès de la Société Française d'Orthopédie dentofaciale
Dr. Merle-Béral, 2, avenue Gambetta, Albi, Tarn
- 23-26—Geneva
International College of Surgeons—20th Anniversary Meeting
Congress Secretariat, 6-8, rue de la Confédération, Geneva
- 23-31—Lausanne
7th International Congress of Comparative Pathology
Secretary General, Prof. Hauduroy, 19, rue César Roux, Lausanne, Switzerland
- 26-31—Lausanne
7th International Congress of Comparative Pathology
Prof. Hauduroy, 19, avenue César-Roux, Lausanne
- 30-June 3—Lucerne
9th International Hospital Congress
Hon. Secretary-Treasurer, Capt. J. E. Stone, International Hospital Federation, 10 Old Jewry, London, E.C. 2, U.K.

JUNE

- 1-4—London
British Medical Association—Annual Representative Meeting
The Secretary, B.M.A. House, Tavistock Square, London, W.C.1
- 6-10—Atlantic City, N. J.
American Medical Association—1955 Annual Meeting
Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Illinois

14-16—Toronto

British Commonwealth Medical Conference
A. D. Kelly, M.B., General Secretary, Canadian Medical Association, 244 St. George Street, Toronto 5, Ontario

16-18—Oslo

The Norwegian Medical Association
The Norwegian Medical Association, Inkognitogt. 26, II, Oslo, Norway

18-19—Stockholm

5th Congress of the International Association for the Study of the Bronchi
Dr. J. M. Lemoine, 187, boulevard Saint-Germain, Paris 7e

20-24—Toronto

Joint Annual Meeting of the British Medical Association, Canadian Medical Association and Ontario Medical Association
A. D. Kelly, M.B., General Secretary, Canadian Medical Association, 244 St. George Street, Toronto 5, Ontario

21-25—London

4th Commonwealth Health and Tuberculosis Conference
The Secretary, N.A.P.T., Tavistock House, Tavistock Square, London, W.C.1

23-24—Birmingham

Society for the Study of Fertility—Annual Conference
Mr. H. H. Fouracre Barns, F.R.C.S., 31, Weymouth Street, London, W.1

24—Istanbul

Turkish Medical Association
Dr. Ahmet Rasim Onat, Pres., The Union of Turkish Physicians, Turk Tahlileri Birliği Merkezi, Konseyi, Cagaloglu, Istanbul

27-28—Paris

Deuxième Réunion Syndicale Internationale des Gynécologues et Obstétriciens
Monsieur le Docteur J. Courtois, 1, Rue Racine, Saint-Germain en Laye (S.-&-O.), Paris, France

30-July 2—London

British Association of Urological Surgeons—Annual Meeting
The Association, 45, Lincoln's Inn Fields, London, W.C.2

JULY

1-2—Cambridge, England

The Thoracic Society—Summer Meeting
Dr. Kenneth Robson, 57a, Wimpole Street, London, W.1

3-9—Bogotá

IV General Assembly and V Pan American Medical-Social Congress of the Pan American Medical Confederation

4-8—Cambridge, England

2nd Congress of the International Diabetes Federation
J. G. L. Jackson, 152, Harley Street, London, W.1

(Continued in May issue)

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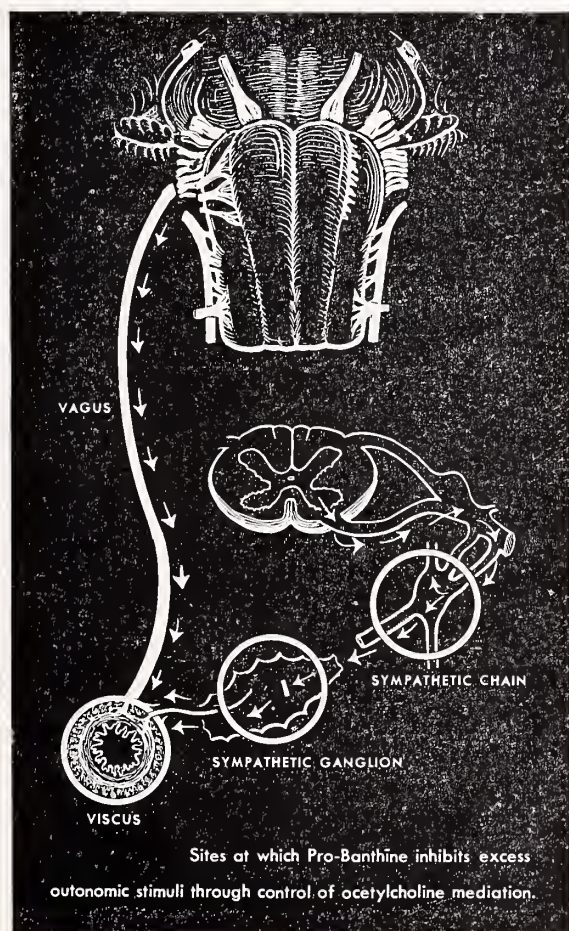
Roback and Beal² found that Pro-Banthine orally was an "inhibitor of spontaneous and histamine-stimulated gastric secretion" which "resulted in marked and prolonged inhibition of the motility of the stomach, jejunum, and colon. . ."

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1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: *Gastroenterology* 25:416 (Nov.) 1953.

2. Roback, R. A., and Beal, J. M.: *Gastroenterology* 25:24 (Sept.) 1953.

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OUR NEIGHBORS

Massachusetts

James M. Faulkner, dean of Boston University School of Medicine, has been appointed medical director of the Massachusetts Institute of Technology, effective this coming summer. He will succeed Dana L. Farnsworth who goes to Harvard University as the Henry K. Oliver professor of hygiene.

Dr. Faulkner will continue to serve Boston University as professor of clinical medicine. Dr. Faulkner's more than seven years as dean have seen a remarkable expansion at Boston University School of Medicine. Research grants have almost doubled, teaching grants have more than quadrupled, and the faculty has increased from 266 to 413. The School's teaching and research facilities have been greatly increased by agreements with several hospitals. M.I.T. is indeed fortunate to secure the services of this devoted servant of medicine.

New York

A \$450,000 student health clinic will be built at Cornell University to honor Frank Gannett of Rochester, president of the Gannett Group of Newspapers and a Cornell graduate and trustee. Funds will be provided by the Gannett Newspaper Foundation which was created by Mr. Gannett. This new development will fill a long standing need for a permanent clinic building centrally located on the campus.

Frank Gannett long has been interested in student health needs and for ten years has supported a campus diet table for Cornell students with unusual nutritional problems.

NEWS

from County Associations

Fairfield

The 163rd Annual Meeting of the Fairfield County Medical Association took place at the Stratfield Hotel in Bridgeport on April 4. The early meeting date was established in order to avoid con-

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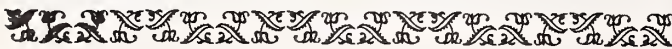
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fusion with a religious holiday on the second Tuesday of April, as called for in the by-laws of the association. A later date would have conflicted with the Annual Meeting of the Connecticut State Medical Society. The guest speaker was Phillip D. Stern of Bridgeport, a member of the lecturing staff of the American Museum-Hayden Planetarium, New York, and numerous astronomical societies.

The Public Relations Committee, Alfred J. Sette, Stamford, chairman, is considering participation again this year in the Danbury Fair in October. The type of exhibit has not been selected.

William Kaufman has been appointed American editor in chief of the *International Archives of Allergy and Applied Immunology*, and contributing editor in the field of psychosomatic medicine for the *Quarterly Journal of Allergy and Applied Immunology*. He is also a member of the Publications Committee of the American Medical Writers' Association.

William J. Lahey, director of medical education at St. Francis Hospital in Hartford and clinical instructor in medicine at Yale University School of Medicine, presented a paper at the March meeting of the Bridgeport Medical Association at Bridgeport Hospital entitled, "Rheumatic Fever Prophylaxis."

Hartford

Last month the Public Relations Committee approved a new project calling for a series of short preprinted messages to be mailed along with physician's statements to patients. These messages will be printed by Hartford County Medical Association and distributed free to any physician member. They will be written in a chatty style and include a wide range of topics. Some of the topics which will be covered are: physicians' vacations, fees, CMS, hospital services, voluntary health insurance and emergency coverage. When the initial messages are printed, all members will receive samples from which they can select the most suitable messages. The Public Relations Committee also approved an initial development of the medical facilities available in Hartford County in order to draw up an association plan to guarantee the services of a physician to every person needing them.

Henry Parlato was recently elected president of the New Britain Medical Society.

Mrs. Charles Jacobson, Jr., vice-president of the Manchester League of Voters (Women), recently became the first woman member of the Manchester

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Town Planning Commission when she was named to fill an unexpired term.

Harvey Sirota succeeds Haymond Houle as president of the East Hartford Medical Society. William H. Lohman was named president-elect. Joseph Danyliw was elected secretary and Arthur Trantolo, treasurer.

Ralph Richardson of Bristol was reelected president of the city's Employees' Health Program last month.

Members of the Council of the Connecticut Society of Gerontology are Harold S. Barrett, assistant deputy commissioner of health for Connecticut, and H. Gildersleeve Jarvis of West Hartford.

The new president of the Manchester Medical Staff is Jacob Segal. Elected as vice-president was Joseph C. Barry and secretary, Edward Besser.

Chief of Staff for the New Britain General Hospital is Bliss Clark. John C. White is chief of medicine, Donald A. Bristoll, chief of obstetrics and gynecology, Roswell Johnson, chief of pediatrics, Paul Rosahn, chief of pathology and John Larking, chief of radiology.

Recently Francis J. Braceland, psychiatrist in chief of the Institute of Living, spoke at both the annual meeting of the Travelers Aid Society of Hartford and West Middle School, Hartford respectively. His topics were, "Taking Care of the Wayfarers," and "Emotional Problems of Everyday Life."

The graduate nurses of Rocky Hill and the Nutmeg Silhouettes of Hartford and Manchester recently heard Wilson F. Smith speak on the problems of weight control.

Charles McLean, director of the cardio-respirator laboratory at Hartford Hospital, recently spoke to the Kiwanis Club of Wethersfield about the new

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diagnostic techniques that are being studied as part of the research program.

BY-LAW CHANGES

Approval of the creation of an accounting-book-keeping service for Hartford County Medical Association members was given last month by the Board of Directors.

The Board also accepted the by-laws committee report which made several changes in the present by-laws. Besides the alterations in membership and the reduction of the Board of Directors, the by-laws concerning medical ethics have been tightened to spell out how the committee shall work.

Principally, the two most fundamental changes are in the inclusion of "other persons, professional or of the laity" who may assist the committee in arriving at fair decisions.

Another important change was the "personal interview" which the complainant may have with some member of the committee "who shall then act as the complainant's representative at the committee meeting which considers the case."

What was formerly the Industrial Health Committee has now been broadened to cover not only occupational health but public health as well. This will mean that this will serve as a liaison group between Hartford County Medical Association and other health agencies operating in the county.

Provision for full voting strength at the State Medical Society's House of Delegates has also been made by the inclusion of a by-law on alternate delegates. If elected delegates cannot serve at the meeting of the House, then the president or the delegate himself may make a selection from the alternate delegates to sit for him. This will enable Hartford County Medical Association always to be at full voting power and avoid the necessity of selecting delegates in a haphazard way.

Middlesex

A. W. Thomson attended the Sixth American Congress on Obstetrics and Gynecology in Chicago recently.

The annual meeting of the Central Medical Society was held on February 17 at the Commodore Macdonough Inn, Middletown. New officers for the coming year were chosen as follows: President, Norman Gardner; Vice President, Aldo Santiccioli; Secretary, John Korab; Treasurer, Sanford Harvey. The speaker was Mr. Hugh A. Harter of Wesleyan University. Mr. Harter spent over two years in Mexico so that he gave a very interesting and

authentic talk on that country. He showed a great many colored slides to point up his ideas.

Irwin Israel, one of the interns last year at Middlesex Memorial Hospital, has been appointed medical examiner for Colchester.

New Haven

On March 6 the Waterbury community celebrated the dedication of the additions to the Waterbury Hospital. Over the past two years there has been a building program going on throughout the hospital. The cost of the program has been two million, seven hundred fifty thousand dollars. The hospital now has four hundred thirty-eight beds and ranks among the two hundred largest in the country. A new phase of building will begin and consist of an enlarged x-ray department and building an addition to the nurses' home.

Ned Shnayerson, professor of surgery at the Polyclinic Hospital, addressed the staff in the St. Mary's staff room March 5 on "Peripheral Vascular Disease, Indications for Sympathectomy." Dr. Shnayerson is chief of Peripheral Vascular Disease Department at Polyclinic.

The monthly scientific meeting of the Waterbury Heart Association was held on March 3 in the staff room of St. Mary's Hospital. Levin L. Waters, associate professor of pathology at Yale University, spoke on "Pathology of Arteriosclerosis."

Carter L. Marshall, a practising dermatologist in New Haven, has received a series of honors from the fraternal order of Elks. He was recently voted "Man of the Year" by the New England Association of Improved, Benevolent and Protective Order of Elks of the World. He was cited in Springfield, Massachusetts for the establishment of the Elks' first successful blood bank and x-ray unit at Baltimore and was also cited recently for "top performance" to the order by the Grand Lodge conference in Philadelphia. Dr. Marshall is a member of the New Haven Board of Health Commissioners and for the past ten years has served with the Connecticut Civil Rights Commission.

New London

The monthly dinner lecture meeting of the Lawrence and Memorial Associated Hospital was held on February 10. The meeting was well attended. The speaker was Dr. William Dameshek, professor of clinical medicine at Tufts University Medical School. His subject was "Recent Advances in Hematology."

The New London Chapter of the Connecticut Heart Association had its monthly cardiovascular

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.:
J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.:
Brit. M. J. 2:755, 1953.


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Brown, H. W.:
J. Pediat. 45:419, 1954.

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lecture on February 24 at the Lawrence and Memorial Hospital, New London. The guest speaker was Dr. Stanford Wessler from Beth Isrel Hospital in Boston, who spoke on the "Management of Thromboembolism."

The monthly meeting of the staff of the William W. Backus Hospital in Norwich was held on February 10. The program consisted of a presentation of the services rendered by the United Workers of Norwich. The speakers were Mrs. Nelson Polsby and Miss Dorothy Peckham. This meeting was followed by a talk by Mr. Bernard Savage on the "Sponsoring of Blood Bank Collection by The Hospital Staff."

Effective March 1, 1955, a new Cardiography Staff was created as a subdivision of the Medical Department of the attending staff at the Lawrence and Memorial Associated Hospital. All electrocardiograms taken in the hospital will now be read by the cardiography staff. Edward Gipstein is chairman of this board and the senior members consist of Alfred Labensky and Hilliard Spitz. The junior members are made up of Frederick L. Dey, William M. Edmonstone, Harold H. Irwin, William J. Murray, Jr., and Joseph M. Wool.

The monthly meeting of the New London County Medical Association was held on March 3 at the Pfizer plant in Groton. The Pfizer Company were our hosts. They provided us with an inspection tour of their large chemical plant, and then entertained us with cocktails and dinner. The scientific session followed, and the speaker for the evening was Perry Colver from the Massachusetts General Hospital in Boston, who spoke on "Ulcerated Colitis and Reginal Iliitis." The meeting was one of the best we have had in many years and was attended by approximately 110 doctors.

Martin Leo O'Neill, a practising physician in Jewett City for 24 years, died at his home on February 25. Dr. O'Neill served several terms as medical examiner for Jewett City and Voluntown.

NEW BOOKS IN REVIEW

A WAY TO THE SOUL OF THE MENTALLY ILL.

Gertrude Schwing. Authorized translation by Rudolf Ekstein and Bernard H. Hall. *New York: International Universities Press.* 1954. 158 pp. \$3.

Reviewed by FRANCIS J. BRACELAND

This volume is the fourth of the International Universities Press monograph series on Schizophrenia and in it the author discusses her methods of establishing a workable relationship with schizophrenic patients. Upon this relationship of

interest and confidence the transference situation is accomplished and the way is prepared for effective psychotherapy. The work is a translation of a book published in German fourteen years ago.

The story is a detailed account of the author's own experiences and reactions as she worked in her capacity as a psychiatric nurse in mental hospitals. Herself an analyst, she sees the quality of motherliness as of the greatest importance therapeutically. She discovered in all of the female schizophrenics she treated a craving for maternal affection under various guises and she found them inevitably individuals who had unsatisfactory relationships with their parents in childhood.

The quality of motherliness in her book differs from mother love, the latter being a quality which man shares with the lower animals and which she sees as disguised egoism. Motherliness implies devotion to the child for its own sake and in order to acquire this quality the therapist herself must undergo analysis.

There will be differences of opinion regarding this latter idea and other ideas she expresses, but we shall not bicker with her for she obviously is a warm, sentient, dedicated lady, interested in sick people, and these qualities make up for differences in opinion. We can agree with her that insulin coma therapy permits an economy of the psychotherapist's energy, reduces the patient's resistance and prepares him for psychotherapy. Without psychotherapy this form of treatment is less effective.

The evidence she presents that interpersonal relationships with schizophrenics is possible and utilizable is welcome confirmation of the present day ideas and beliefs.

CIBA FOUNDATION—SYMPOSIUM ON HYPERTENSION: HUMORAL AND NEUROGENIC FACTORS. Editors for the Ciba Foundation: *G. E. W. Wolstenholme, O.B.E., M.A., A.B.L.S., and Margaret P. Cameron, M.A., A.B.L.S.,* assisted by *Joan Etherington.* Boston: Little, Brown and Company. 1954. 294 pp. with 73 illustrations. \$6.75.

Reviewed by HUGH L. DWYER

This volume comprises material presented at the Symposium sponsored by the Ciba Foundation. Some thirty-three leading investigators participated in this meeting. The book contains 21 papers on various aspects of the subject in addition to the opening and closing remarks of Professor G. W. Pickering who acted as chairman for this four day conference. Each paper is fully discussed by several selected leaders whose work has given them interest and competence in the specific material presented.

The work of this conference is published largely for reference value. It is not intended to serve as a review of the clinical aspects of hypertension or as a guide to its therapy. The greater portion of the papers deal with research on the humoral and neurogenic factors in hypertension. Much of it relates to studies in experimental hypertension. A smaller portion of the material deals with studies incidental to chemotherapy, and the clinical aspects of the subject.

The book will find its greatest use as a reference source for the investigator. It will have very little value to the clinician. It does serve as interesting reading to the clinician interested in the fundamentals of the subject. The discussions in particular will serve to illuminate one's perspective over the whole field of hypertension, our present state of knowledge and the distance yet to be traveled.

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B.S. Med., Wake Forest College, 1914

M.D., New York University & Bellevue Hospital Medical College, 1916

Intern, Brooklyn Hospital, 1916-1917

1st Lieutenant, U.S.A., M.R.C., 1917-1918; Captain, 1918-1919

General Practitioner, Springdale, Connecticut, 1919-1924

Pediatrician, Stamford, Connecticut, 1924—

Instructor in Pediatrics, 1924-1927; Associate Pediatrician 1927-1937; Assistant Professor of Clinical Pediatrics 1937, New York Post Graduate Hospital & Medical School

Assistant Professor of Clinical Pediatrics (P-GM), New York University-Bellevue Medical Center

Attending Pediatrician, Stamford Hospital

Director of Pediatrics, Stamford Hospital, 1942—

Licentiate, American Board of Pediatrics

Fellow, American Academy of Pediatrics

Editorial Board, Connecticut State Medical Journal, 1937-1945

Member of Executive Board, American Academy of Pediatrics, 1943-1950

Fellow, American Medical Association. Alternate Delegate from Connecticut, 1949-1953

Chairman, Pediatric Section, American Medical Association, 1953-1954

Chairman, Board of Trustees, Fairfield County Medical Association, 1947-1951

President, Fairfield County Medical Association, 1951-1952

Member of World Medical Association



THE PRESIDENT'S PAGE

To my colleagues throughout the State, I extend my warm greetings as I assume the responsibilities of President of the Connecticut State Medical Society. I feel proud and grateful that you have given me the opportunities, commensurate with the leadership of this medical group, to further serve my fellow man through the agency of medicine. If we stop for a moment to think, no other profession offers such a wide variety of methods for doing good and at the same time pays such high rewards for a job well done.

The most important purposes of the State Medical Society are: "to extend medical knowledge and advance medical science; to elevate the standards of medical education; and to promote friendly intercourse among the physicians; to enlighten and direct public opinion so that the profession shall become increasingly useful to the public in the prevention and care of disease and in prolonging and adding comfort to life."

In the Fall of 1953 it was my privilege to attend the meeting of the House of Delegates of the AMA, as the Alternate Delegate for the late Dr. Joseph Howard. During this session it was my lot to have many valuable experiences and thrills. The outstanding thrill came at the opening session when the Speaker of the House invited the Rev. Alphonse M. Schwitalla, S. J. to address the Delegates. This short, stoutish gentleman, clad in the clothes of his office, slowly made his way to the platform. Not having seen him before, I was struck by the radiance of his personality and the merry sparkle of his eyes. He opened his remarks as follows: "Being a Jesuit priest precludes any possibility of my ever attending a conclave of the Cardinals for the election of a Pope, so my next ambition has been, before I die and make a report to the Big Boss, at least to have once appeared before the House of Delegates of the AMA. The American Medical Association is composed of a group of sound thinkers and in the work that I have done I have felt that whenever I have made a false step it was always because I had done something that was contrary to what the American Medical Association has taught. Just yesterday I was reading up on old Grecian medicine and I was amazed to find that way before the Homeric days the Greek doctor was called a *Demiourgos*, that is, a worker for the people, and through all these centuries, gentlemen, you have been *Demiourgoi*, working for the people."

In like manner, the members of our Society are *Demiourgoi*, working for the people, thus making our organization a *Demiourgos*, that is, a worker for the people. The success of our State Medical Society in fulfilling its mission as a "helper of the people," is dependent upon the contributions of each and every one of us. Won't you join with me in dedicating ourselves anew to the service which is our right and privilege to render our fellow man?

Our State Medical Society consists of over 3,000 members. It is interesting to note that 2,131 have joined in the last twenty years; 1,312 in the last ten years. From these figures it is understandable that over 2,000 members know little of the progress our Society has made in the past twenty years. During the ensuing year I will call to your attention the high lights of this progress and what your Society means to you.

Oliver L. Stringfield, M.D.

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SEVERE UPPER GASTROINTESTINAL HEMORRHAGE:

EARLY USE OF DIAGNOSTIC TECHNICS

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TECHNICS for emergency control of severe upper gastrointestinal hemorrhage have been developed to a high degree and, if the drop in mortality figures has been a bit discouraging, it cannot necessarily be blamed on technical ineptness. Rather, it must be admitted that too often it is necessary to carry out emergency therapy in the face of frightening diagnostic myopia. Skillful esophageal tamponade will not help the cirrhotic patient who is bleeding from a duodenal ulcer rather than from his esophageal varices, nor will an emergency gastrectomy stop the hemorrhage of the ulcer patient who happens to be bleeding from esophagitis. In short, emergency therapeutic technics are available and effective but they become as nothing unless properly directed.

Because the results of emergency therapy of severe upper gastrointestinal hemorrhage at this hospital have been discouraging in the past due to misdirection, a "vigorous diagnostic approach" was adopted.

TECHNIC

The governing principle is that the doctor who is responsible for the patient with upper gastrointestinal hemorrhage must let as little time as possible elapse before he identifies with assurance the source of the hemorrhage. This calls for esophagoscopy, gastroscopy and radiologic examinations, in this order, as soon as the patient comes under medical surveillance. The two endoscopic procedures permit positive identification of bleeding sites in pharynx, esophagus and stomach and, with the help of roentgen study, indirect identification of bleeding sites in the duodenum. Present experience with the technic is limited to hospital application, although, except

SUMMARY

Accurate localization of the source of bleeding in the case of severe upper gastrointestinal hemorrhage permits the most efficient application of available therapeutic measures. The early use of esophagoscopy, gastroscopy and roentgenology has been evaluated in a series of 163 cases and compared with a control group of 212 patients. Direct, on-the-spot visualization of the lesion actually responsible for the hemorrhage made it possible to direct treatment specifically. A significant reduction in mortality was achieved.

for x-ray studies, the procedures have the advantage of a fair degree of mobility. They are most expeditiously carried out in the hospital's admitting room. The ward examining room or a ward bed is suitable, but there is no good reason to move the patient from the admitting stretcher until he reaches the x-ray room.

As soon as the patient is admitted to the emergency room, blood is drawn for cross matching, and blood replacement begun and continued—freely—as the clinical course may dictate. The diagnostic manipulations may be carried out without important inconvenience even when transfusions are being given into three extremities. Meanwhile the history and physical examination are accomplished as completely as the clinical situation will permit, an assistant is dispatched to collect available previous clinical records and roentgenograms, and the radiology department is alerted for the imminent fluoroscopic examination.

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From the Gastroenterology Service, Walter Reed Army Hospital, Washington, D. C.

As soon as the history is completed a Fr. 30 Ewald tube is passed into the stomach and ice-water lavage carried out. It is worse than useless to employ any but a large-caliber tube for this. In a sense, lavage is the most important part of the technic, for the success of the whole venture depends on a clean esophagus and stomach. Several quarts of ice water and a half hour may be required. It is a remarkable thing that the lavage stops the bleeding for an hour or more in approximately two-thirds of the patients, even bleeding which is originating from esophageal varices or from large, ulcerated sclerotic arteries. This important therapeutic virtue of ice-water lavage, once rather widely utilized for emergency treatment, at times adds to the endoscopist's problem, because at least a small amount of bleeding must be visualized if a certain diagnosis is to be established.

Esophagoscopy examination is made as soon as the Ewald tube is withdrawn. No sedation or oral anesthesia is ordinarily used. The esophagoscope must be passed under direct vision rather than with the help of an obturator, both because recent roentgenologic information will rarely be available in the patient's case and because in this situation it is important to inspect the hypopharynx on the way down.

Discovery that the bleeding lesion is within the esophagus frequently permits effective treatment on the spot. If physical examination has suggested cirrhosis, it is well to pass a Sengstaken tube and to inflate the gastric balloon immediately prior to esophagoscopy. Then detection of bleeding varices permits injection of a sclerosing solution, if one should wish, and immediate inflation of the esophageal balloon. This, of course, precludes gastroscopic examination and the opportunity to obtain early information about the presence of gastric varices. In this hospital it is customary to take the opportunity to measure the portal pressure within the varices through the injecting needle prior to sclerosis. The finding of bleeding esophagitis or esophageal ulcer calls for passage of a Sengstaken tube.

Gastroscopic examination immediately follows esophagoscopy, unless the latter has shown the stomach to be refilling with blood, whereupon lavage must be repeated first. Usually the gastroscopist is amazed by the clean state of the stomach and by the completely satisfactory examination which is possible. Bleeding lesions are usually easily

located; specific identification may be impossible if there are large adherent clots. The discovery of fresh blood running back into the stomach through the pylorus permits a presumptive diagnosis of bleeding duodenal ulcer, although in the present series this assumption could never be confirmed roentgenologically in one instance.

Fluoroscopic examination immediately follows gastroscopy, even though the bleeding lesion has already been found. If a Sengstaken tube has been passed, the opaque medium is introduced through its central channel. It is believed that the radiologist should use whatever manipulations he feels necessary in order to obtain the maximum amount of information from his examination. If abdominal palpation is not used freely, fluoroscopy may as well not be done.

In some instances it is possible for the clinician to have at hand complete and definitive esophagoscopy, gastroscopic and roentgenologic information within an hour of the patient's admission. In others, various considerations might change the routine of the work-up or lengthen the period of study. Thus, if it appears at the time of hospitalization that the bleeding has stopped, it has been the practice to do the roentgenologic examination first, in order that the endoscopist may have the advantage of the roentgen findings. Although it is believed that all information should be obtained as quickly as possible, endoscopic examination will be far more fruitful if performed upon reactivation of the bleeding.

MATERIAL

In order to examine the effectiveness of the "vigorous diagnostic approach," two series of personally observed, severe upper gastrointestinal bleeders are compared. These are additive series and have already been reported in part.^{1,2} Because blood for replacement has always been readily available, the amount required for transfusion has given a fair indication of the severity of bleeding. As an arbitrary criterion for inclusion in the present study, a requirement of at least 1000 ml. in the first six postadmission hours was chosen.

The control series was composed of 212 patients in whom no search was made for the bleeding site until at least seven days had passed since cessation of hemorrhage, except that permitted during emergency laparotomy in 25 patients. The working diagnosis was based on the initial history and physical

examination, and much emphasis was placed on a history of a previously diagnosed upper gastrointestinal lesion, or, in the absence of such a history, on the statistical expectancy of the common bleeding lesions. The direction in which therapy was directed was, therefore, based entirely on clinical acumen. All patients who survived the hemorrhage were eventually submitted to thorough diagnostic study, including roentgenologic study in all, esophagoscopy examination in 166 and gastroscopic examination in 164.

The series submitted to early diagnostic study was composed of 163 patients. The details of diagnostic management varied to some extent from patient to patient, and the ideal program as outlined above was not approached in the earlier cases. As experience has accumulated it has seemed more and more important that the schedule be strictly adhered to, so that in 53 recent instances all diagnostic studies were completed within 24 hours of hospitalization, except when gastroscopy was precluded by insertion of the Sengstaken tube. In some of the other patients the studies were not completed until six days of hospitalization had passed. The examinations that were actually performed during hemorrhage included esophagoscopy in 105 instances, gastroscopy in 136 and contrast fluoroscopy in 159. There were 24 women and 12 Negroes among the 163 patients, and the number of patients per age-decade from the second decade through the eighth were, respectively, 6, 37, 42, 31, 25, 19 and 3.

TABLE 1
CONTROL SERIES: COMPARISON OF WORKING DIAGNOSIS AND FINAL "CORRECT DIAGNOSIS"

DIAGNOSIS	WORKING DIAGNOSIS (NO. CASES)	"CORRECT DIAGNOSIS" (NO. CASES)
Duodenal ulcer	134	32
Esophageal varices	45	68
Erosive gastritis	6	22
Gastric ulcer	3	16
Hiatus hernia	3	13
Esophagitis	2	7
Others	19	23
Undetermined		31

RESULTS AMONG THE CONTROL SERIES

The initial working diagnosis eventually proved to be correct in 35 per cent of 212 patients (Table 3). Because none of the lesions in the control series was studied during hemorrhage, decision as to the

TABLE 2
VIGOROUS DIAGNOSTIC APPROACH: DIAGNOSES AND METHOD BY WHICH ESTABLISHED

DIAGNOSES	CLINICAL	ESOPHAGOSCOPY	GASTROSCOPY	X-RAY
Duodenal ulcer			2	30
Gastric ulcer			5	14
Gastritis			31	
Esophageal varices		20		
Gastric varices			5	
Mallory-Weiss syndrome		7		
Weber-Osler-Rendu disease	1		3	
Hiatus hernia	5		1	
Esophagitis	7			
Esophageal ulcer				1
Benign intramural gastric tumor			1	
Prolapse gastric mucosa into esophagus		1		
Jejunal polyp			1	
Stomal ulcer			1	
(Undetermined: 27)				

TABLE 3
COMPARISON OF THE EFFECTIVENESS OF DIAGNOSIS AMONG THE TWO SERIES

RESULTS	DELAYED DIAGNOSTIC APPROACH (PER CENT)	VIGOROUS DIAGNOSTIC APPROACH (PER CENT)
Immediate diagnosis correct.....	35	83
Emergency therapy proved optimum.....	55	86
Source of hemorrhage not determined....	15	11
Deaths from hemorrhage.....	8	4
Emergency therapy had been directed at correct diagnosis.....	56	100
Emergency surgery	12	18
Preop. diagnosis correct.....	28	100
Operative procedure proved to be optimum	56	100

"correct diagnosis" was necessarily always made by inference only, based on posthemorrhage study and on clinical judgment. In 31 patients no potentially bleeding site was ever located. As Table 1 illustrates, duodenal ulcer was badly overdiagnosed, this being explained by the pressure of statistical expectancy which is felt whenever one must deal with hematemesis of unknown origin. Similarly, esophageal varices, gastritis, gastric ulcer, hiatus hernia and esophagitis were badly underdiagnosed.

The history of a previously diagnosed potential bleeding lesion was obtained at admission from 68 patients, and in all but five emergency therapy was directed at this lesion. In the final analysis it was

found that 51 per cent of these lesions had not accounted for the current hemorrhage.

Eighteen patients died as a result of hemorrhage, five following emergency surgery. All were autopsied. The bleeding lesion was found to be esophageal varices in nine patients, erosive gastritis in three, gastric ulcer in one, duodenal ulcer in two, esophageal ulcer in one, and leukemia of the stomach in two. The working diagnoses had been correct in 10 of the 18 patients.

Twenty-five patients were treated by emergency surgery. The preoperative diagnosis proved correct in seven. An effective operative procedure could be carried out in only 14.

RESULTS OF VIGOROUS DIAGNOSTIC APPROACH

The initial emergency diagnostic studies permitted identification of the bleeding lesion on the spot in 136 or 83 per cent of the 163 patients. Among the other 27, additional study eventually revealed a plausible diagnosis in 10 more. As a result of successful early diagnostic efforts, 29 patients were treated by emergency surgery during or shortly after the acute bleeding episode, the disease in 10 instances being duodenal ulcer, in 8 gastric ulcer, in 9 esophageal varices, and in 2 hiatus hernia. Seven patients of the series died during the period of observation, the diagnosis in two being duodenal ulcer, in two gastric varices, and in one instance each, acute erosive gastritis, gastric ulcer, and esophageal varices. All were studied at autopsy.

The diagnoses and the method by which established are presented in Table 2. It is to be noted that some of the diseases would be recognizable only by esophagoscopy, some only by gastroscopic examination, and some only roentgenologically. It is to be noted, too, that the radiologist usually examined the patient last, so that his diagnoses had frequently already been made by the endoscopist.

RESULTS: COMPARISON OF THE TWO SERIES

The significant consequences of the diagnostic efforts among the two series are compared in Table 3. There are important differences. The figures need no interpretation or elaboration.

COMMENT

In clinics the world over the main deterrent to diagnostic study of the patient with massive upper gastrointestinal hemorrhage—a situation which makes a desperate demand for quick and accurate

diagnosis—seems to be the fear of aggravating hemorrhage. Medical training often is directed in such a way that the doctor finds himself instinctively afraid of his patient with gastrointestinal hemorrhage. In particular, there appears to be prejudice against passing a tube through an esophagus which may contain bleeding varices and against palpating an abdominal wall which may overlie a bleeding ulcer. If facilities are not available for blood replacement, possibly such fear can be justified. In the hospital environment, however, it is believed that such fear will lead to disservice to the patient, and can only be interpreted as an effort on the doctor's part to treat himself rather than his patient. The hoary dictum, "*Primum non nocere*," may be a remarkable shortsighted one in the face of massive hemorrhage. The harm to the patient will result from failure to attempt to diagnose, rather than from efforts exerted in the patient's behalf.

To date nothing has been observed to suggest that the "vigorous diagnostic approach" has aggravated hemorrhage or in any way compromised the patient's chance of survival. To reiterate, ice-water lavage has proved remarkably effective in stopping hemorrhage in most cases. Skillful passage of tubes and instruments will not initiate or aggravate variceal bleeding. A large experience with the needling of varices indicates the innocuousness of mechanically disturbing the continuity of the varix wall in this way. The radiologists who have cooperated in this venture similarly have had no reason to regret thorough fluoroscopic examination.

It is apparent that early establishment of a precise diagnosis is important in clinical management, whatever form treatment may take. Its value is most dramatically shown when the decision is to attempt emergency surgery. Blind emergency gastrectomy—so frequently resorted to of necessity with the realization that the chance that it will prove to be the proper procedure depends on the tenuous statistic that most bleeding is due to duodenal ulcer—becomes obsolete. Emergency operative procedures become specifically directed. With elimination of guesswork the results prove immeasurably better.

Two of the revelations of early diagnostic study were particularly unexpected. First, it was clear that little weight can be placed on a history of a previous diagnosis in guessing at the cause of a current hemorrhage. In the present study this mainstay of the conservative diagnostic approach proved wholly unreliable.

Second, when the lesions that were actually seen to be bleeding were compiled, as in Table 2, it was found that the list did not support the supposed relative frequency of bleeding lesions. Thus, duodenal ulcer was found to be responsible in only 19 per cent. Furthermore, several diagnoses which do not ordinarily appear in such lists appear prominently here. Because of inherent differences in patient populations, it is not possible to compare the present series with those reported by others, but the question must now arise as to how accurately one may lay the blame for hemorrhage if the lesion is not actually visualized during bleeding. The accu-

acy of the second column of Table 1 is seriously questioned on this account: i.e., the "correct diagnosis" in the control series, as in series reported by others, necessarily had to be determined merely on the flimsy evidence afforded by the finding of a lesion which is capable of bleeding in a patient who has bled.

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PRACTICAL CONSIDERATION OF EYE DISEASE

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CATARACTS

Many of my nonophthalmologist friends have asked me if there is anything to the curing of cataracts with fish lens protein. In answer to this question I should like to quote an editorial titled "Pisces Vobiscum" in a recent issue of *American Journal of Ophthalmology*. It should especially be of interest to those of you who have a soft spot in your heart for fishing.

PISCES VOBISCUM

Not far away from my island fishing camp in Canada where I spend the summers is a place called Isle D'Oeil, or "Easily Oiled" as the natives say. It belongs to a promotor chap named Salop. He passes, according to himself, as an expert on all sorts of things, particularly marine life and chemistry. It seems that at one time or other this character had either edited, annotated, embellished, or written a learned foreword to a book called "Twenty Thousand Leagues Under The Sea." Or at least he was always planning to do this. Whether he ever got around to it or not, I do not know. As for chemistry, he made his own gin, and judging from his appearance and behavior, he must have consumed a lot of it, during prohibition and since. Everyone knows

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SUMMARY

There is no medical cure for cataracts. This is illustrated by a quoted humorous editorial. Substituting an acrylic lens for the extracted lens in cataract operation is not generally favored. Strabismus should be treated surgically at an early age and by an expert. Operations for myopia have been tried but not yet perfected. Diamox is of value only in certain types of glaucoma. Contact lenses are efficacious in cases of high astigmatism, keratoconus or bulging of the cornea. Cases of keratoconus are the most ideal for corneal transplantation.

that the manufacture of gin requires a practical knowledge of chemistry. At any rate, I can certify that he is an expert on the alcohols, which I recall, along with the benzene ring, make up most of organic chemistry. So I naturally turned to him for help in solving a serious piscatorial problem that deeply concerned me.

There is a quiet pool, surrounded for the most part by lovely pines and granite boulders, quite

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nearby. It is the favorite spot for bass and it has been a peculiar habit of mine to slip into this pool quietly in my canoe and catch a few for the frying pan. Early this summer I went over there to try my luck. After a number of hours of hard work, that is to say hard from a fishing viewpoint, I did not get a nibble. This puzzled me, for I could clearly see at least 20, three or four pounders lazily flapping their fins. I tirelessly tried my elaborate and expensive repertoire of bait, both live and artificial, dangling it in front of their various noses with appropriately enticing jiggles and succulent erotic motions, all in vain.

Just when I was about to give up, I remembered having read of a maneuver, hilariously known as "tickling," described by various literary British piscators. Having had some first-hand knowledge of the veracity of that race of fishermen, particularly the Scot, I was afraid that the report might have been exaggerated. However, the simple operation seemed to be worth a trial. I carefully leaned over the edge of the canoe, quietly slipped my hand and arm into the water and very slowly reached under a fine large bass who appeared to be fast asleep. At the risk of upsetting the balance of nature in producing, by biogenic stimulation (Feeletov) a premature spawntation, I wriggled my forefinger back and forth. When he was completely relaxed by this titillation, I suddenly grasped him through the gills and flopped him into the canoe. I am sure that you won't believe this; I wouldn't have either.

When we both had recovered from our surprise, I began to look him over. He was a dandy specimen of his kind, except for the fact that he was blind with cataracts. Presumably all of these reluctant fish had cataracts. This was a much more complicated problem than a purely personal one. It concerned social security and the Welfare State. It needed immediate action, for as soon as the bureaucrats in Washington heard of this, they would at once set up a special task force, call it "Operation Fish Lens" and overstaff it with broken-down politicians, do gooders and left wingers. Our exorbitant taxes would go up another notch and all sorts of rules, regulations, and forms would be made to protect the poor fish from predatory exploitation by us White Collars.

In my distress I turned to Salop, whom I found deeply immersed in his own special brand of chemistry. He was alert enough, however, to size up the problem and to grasp the possibilities.

"It is well known," he said, "that humans and fish have much in common. It is also a fact that the proteins of lenses are organ, and not species, specific, albeit not soluble in alcohol, I regret to say. It follows, therefore, that the feeding of human lens materials to these fish should absorb their cataracts."

I was suitably impressed with this brilliant reasoning and he went on to say:

"All we have to do, therefore, is to ask our colleagues, especially the ophthalmic residents, to send us the cataracts that they are removing in masses and at great expense (to the patient, that is) all over the country."

Once we obtained these lenses, the rest would be quite simple, according to Salop. So I sent out a batch of telegrams to my colleagues, friendly and otherwise, and in a few days barrels and buckets filled with undressed cataracts, just in their incipency, arrived by plane, boat, and rail.

The dressing of the lenses, that is to say the separation of the vitreous still clinging to them, turned out to be a formidable task. For the benefit of those many authors of statistical reviews of their own cataract surgery who have obviously never seen vitreous, let me say here that it is a transparent, thickly viscous material, extremely slippery when stepped upon.

Soon the rock upon which we were working was covered with a thick layer of this tenacious stuff. This proved to be a dangerous carpet, especially for Salop with his habitual unsteadiness of gait, so I tied him to a pine tree and left him beating time with a gin bottle to this lyric of his own composing. Appropriately, the tune is "My Maryland" ("Tannenbaum"), for he had once done some investigation in a famous eye lab there, or so he said.

EHEU

Poor old fish who cannot see,
How so sad I am for thee!
How wise of you to come to me,
For soon you'll see, I guarantee.*
Here is, for you, some fish lens fare,
And short, I'm sure, you'll be aware
Of all there be, that interests thee
On land, in air, or on the sea.

I spread the dressed cataracts out upon a smooth rock, in even rows, and in a short time the fumes of alcohol and the heat of the sun had permeated the permeability of the capsules so that dehydration,

*Alternate line—'Twill cost a pretty fee, you'll see.
(Author.)

which is a chemical action, quickly took over. They were easily crushed with a lawn roller and produced a fine glistening powder, not unlike mica. All of the lens proteins, from alpha to omega, lay exposed to view and could be readily identified. They formed a scintillating picture. Their pH was 6.7, the specific gravity 1.002, but the isoelectric point and other scientific data, I regret to say, were lost because while I was dictating the protocol to Salop, he fell soundly asleep.

After the powdery material was dried sufficiently we put it in buckets covered with mosquito netting to keep it sterile. Each day for several weeks we dumped several hundred grams of the stuff, which looked very much like fish food, into the pool of the blind fish. We could watch them happily chomping on the flakes, drifting down upon their noses.

At this point in our scientific experiment, Salop disappeared for a few days and on his return he told me that, convinced of the positive success of the experiment and its commercial possibilities, he had formed a corporation called the Corkedtight Cataract Asylum, and had already sold several thousands of shares mostly to fisheries. I think the reason why these people bought in was to insure the escape of more fish from their nets. Blind fish are easily netted. The fewer fish netted the greater is the scarcity and therefore the higher the price. I strongly suspect, too, that the Government would later subsidize this venture for the philosophy of scarcity is firmly established.

Salop also showed me the latest copy of *Tibe*, a well known weekly news review, which is, I think, the house organ of some soap manufacturer or other. In a prominent place, under Medicine, was a characteristically written article describing Salop's discovery and generously giving a footnote supplying his office address and hours of business. The choice of this periodical in which to announce to the world this stupendous piece of news was a very wise one, for every one knows that he has only to read *Tibe*, and nothing else, in order to get the latest scientific information.

I daily visited the pool, testing the outcome of the experiment by casting lures in front of our fish, with negative results, and I began to suspect that something was not quite right. Not so Salop who was ecstatically busy answering hundred of letters, shipping out cartons of powdered lenses and banking the returns.

Toward the end of the summer I was completely convinced that the stuff wouldn't work, but said nothing about it, realizing the futility of going against the great authority of *Tibe*. I resolved, however, to return to the task next summer. Only this time I would replace the cataracts with acrylic lenses. In the matrix of these artificial lenses I purpose to insert some radioactive isotope, P155. Then all I shall need to find and catch my fish will be a special lure containing a small Geiger counter. The clicking noise will not only attract the fish but also the P155. You will surely hear about this later in either *Tibe* or *License*, the journal of the A.A.A. of L.

Georg Bartisch, 2nd

Without going into the details my conclusion is that medically there is nothing which can cure cataracts. As a matter of fact, use of fish lens protein can endanger the eye so that it might be lost when extracted because of lens hypersensitivity. This is called phakoanaphylactic reaction. The person who published the data on the cure (so called) of cataracts with his fish lens protein has been said to have had a very questionable past history and (professional) background. Fish lens protein is no longer available on the market.

Many lay people and medical doctors have made inquiries with reference to the acrylic lens implant of Dr. Ridley as a substitution for the lens which is extracted in cataract operation. For those of you who are not acquainted with this work, at the time of the removal of the cataract, an acrylic lens is substituted for the cataractous lens with the hope that the patient would not have to wear a thick post-cataract lens. I have just returned from a meeting of the Seventeenth International College of Ophthalmology, and have found (from my personal discussions with practically all the leading eye surgeons of the world) that this substitution has been attempted in many centers in the world, but with the exception of Dr. Ridley and a few others very few favor its use. In the future if the many problems accompany the use of an acrylic lens are solved, the possibilities of this substitution might be achieved.

STRABISMUS

Many persons, especially pediatricians, have asked me time and again at what age an ophthalmologist would like to see a child with a question of strabismus. As you know, many children, especially those with broad epicanthal folds or the so-called flattened

nose, have a simulated strabismus. The question of the age was well answered in a question of multiple choice nature given in an American Board of Pediatrics examination about four or five years ago at which time the correct answer to be checked was: "anywhere from six months to six years." Although some work is being done to show that the eyes work together earlier than six months, it is at about this age that most of us feel the eyes are worked binocularly. Actually, six years is a very late age because all occlusion and surgery should be done well before this time. I would also like to remind you of the value of searching most carefully for a person who is capable and at the same time has a genuine interest in both children and in the basic problem of strabismus in all of its many and manifold aspects. Many ophthalmologists, for one reason or another, do not care to deal with children with a question of the crossing of the eye. As a matter of fact, in certain cities where there are twenty-five or so ophthalmologists you might find only four or five who actually do any amount of this surgery and carry through with this problem. Make certain that the person to whom you refer patients of this nature is one who is genuinely interested in the problem of strabismus.

MYOPIA

Going on to another subject—myopia—because many of us have members of our families or patients with this problem, I should like to answer some questions concerning treatment of myopia with eye exercises. This study was very carefully carried out by a large group of optometrists and ophthalmologists in the city of Baltimore and the conclusions reached were that although a person can learn to interpret more letters with eye exercises it does not actually cure the basic organic problem. Any benefit is a temporary one. For full details on this study I should like you to refer to the *Johns Hopkins Bulletin*. Time and again my friends have asked me if myopia might be cured with surgery. Actually several operations have been proposed for the curing of myopia and some have actually been tried. Perhaps the most promising of these is an operation devised by Professor Sato of Japan. The principle of his operation is to introduce a fine special knife into the anterior chamber of the eye and cut small scars on the back surface of the cornea, thus reducing the length of the eye. I had an extensive conversation with Dr. Sato personally, and previously had read his papers very carefully because several of my

friends were experimentally trying to produce cure of myopia by directly cutting off portions of the cornea. Although Dr. Sato's operation technically is simple enough for one who does operative eye surgery, I do not think that I would want this operation tried on me—I am a near-sighted person—nor on my children at this time. Again, maybe the future will bring improvements in this operation. The second operation proposed is an operation which I have been using successfully in patients with very difficult cases of retinal separation or detachment, especially those that are recurrent. This operation consists of cutting out a wedge of the sclera at about the equator measuring about 4 mm. in width. This goes completely around the globe. This operation has been known to correct a myopia of even ten diopters. However, despite the addition of fascia lata slings to reinforce the shortening, the eye again will stretch in the operated area or in other areas. Although I perform this operation myself as I have said for recurrent and bad cases of retinal separation, again I do not feel that I would want it tried for myopia on any of my own children at this time. In the cases of the retinal separation where I have used this operation successfully, although the eye may again stretch, the retina is in many instances flattened permanently. In myopes, the myopia would only recur.

DIAMOX AND GLAUCOMA

Many ophthalmologists have asked me about the new miracle drug Diamox for the cure of glaucoma. Many lay people have likewise asked me questions about the use of Diamox because they have read incomplete newspaper reports on this drug. In considering glaucoma, to simplify it for patients, I often tell them that glaucoma consists of those changes bringing about an increased pressure in the eye. Normally the upper limit of ocular pressure is 25 mm. of mercury with a Schiötz tonometer. I tell my patients that in glaucoma in all probability something goes wrong with the plumbing system. I have drawn on the blackboard a diagram for you in which you see a faucet leading into an inlet pipe which in turn enters this round structure which I have called the eye. On the far end you will see another pipe which I have called the outlet pipe. All of you know that the drugs pilocarpine and eserine are used medically in the treatment of glaucoma. On my diagram is shown a devil stepping on the outlet pipe. You note the weight of the devil closes off the outlet pipe so that the ocular

pressure rises above 25 mm. of mercury. Let us compare pilocarpine and eserine to this little angel which I diagram for you with his or her lasso catching the devil by the neck and pulling those feet off that outlet pipe. In any case we feel that perhaps pilocarpine and eserine do the same by opening the angle of the eye so that fluid can move to the canal of Schlemm. In the case of this new drug, Diamox, we have now placed on the inlet pipe a little angel who, by stepping on the inlet pipe, does not permit so much fluid to enter the eye, thereby lowering the ocular pressure. In a sense, Diamox acts medically like an operation that we call cyclodiathermy does surgically. In cyclodiathermy we apply a barrage of coagulating units over the ciliary body where much of the aqueous is formed, thus perhaps decreasing the amount formed. At first our enthusiasm for Diamox (in large doses compared to that used by the internists) was so great that we felt that all types of glaucoma would respond. However, now we know much work is to be done because Diamox is helpful only in some types of glaucoma such as in acute stages of congestive glaucoma and in secondary glaucoma if used with correct local medications. Diamox cannot be used at this time for any long period of time without side affects, increased dosage, and supplemental drugs.

CONTACT LENSES

Coming to the last subject under discussion, many have asked me about the use of contact lenses

and corneal transplantation. As you know, the two have many similarities. As far as I am concerned, and this is only a personal opinion, the only two indications that I know for the use of contact lenses are for extreme astigmatism and for a disease keratoconus or bulging of the cornea. I sincerely hope that none of you in this audience are wearing contact lenses to disprove me because I am sure that actors and some professional people do wear these glasses and tolerate them for short periods of time. I have had some firsthand experience with the use of contact lenses because while in Germany in 1945 and 1946 we were near a large, well known optical company where they were very carefully made and ground for our GIs for the reasonable price of a carton of cigarettes. Invariably most of these, in fact all of them, ended up in the drawer. I did not know of one GI who continued to wear them. Where a contact lens will work is in the case of a patient with high astigmatism or with keratoconus or bulging of the cornea. These patients will tolerate it and must tolerate a contact lens because they cannot see without it.

CORNEAL TRANSPLANTATION

What are the indications for corneal transplantation? Cases of keratoconus which I have just described are the most favorable. Those who have a good healthy retina behind the cornea with no glaucoma and with a clear border in the periphery of the cornea likewise are good candidates for corneal transplantation.

ACUTE CHOLECYSTITIS IN THE AGED

A PLEA FOR EARLY SURGERY

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SUMMARY

There is no typical course in acute cholecystitis in the aged. Perforation of the gall bladder is more common in this age group than in younger individuals. There are no pathognomonic signs, symptoms or laboratory findings of perforation of the acutely inflamed gall bladder in the aged. Therefore early surgery is recommended.

A few cases are presented to illustrate some of the difficulties in the management of acute cholecystitis in the aged.

As recently as August 1954, Doubilet, Reed and Mulholland¹ proposed that the preferred treatment of acute cholecystitis is operation performed during a quiescent stage of the disease. They maintained that emergency surgery is rarely necessary and, if done, should be limited to cholecystostomy. However, in their series of 97 patients, fully 18 per cent had perforated at the time of elective surgery. In their opinion perforation is not an absolute indication for emergency operation, even in the presence of increasing signs and symptoms. In various series in the literature the mortality following a walled-off perforation is reported as being from 0 to 25 per cent, while when free perforation occurs, the mortality may be 16.6 per cent to 50 per cent.

A recent experience with acute cholecystitis in the aged at Milford Hospital raises the question as to the wisdom of the delayed management of these patients.

Acute cholecystitis is predominantly a disease of older age groups. As a matter of fact, studies have shown that biliary tract disease is the most common cause of abdominal surgery in the elderly patient. Despite many advances made in the preoperative, operative, and postoperative management of surgical patients, there still is an ancient dread of surgery on the part of physicians where older patients are concerned. The following cases illustrate some of the consequences of such thinking.

CASE I

An 85 year old, white male was admitted to the hospital because of left lower lobe pneumonia and congestive failure. Five years prior to admission he first suffered attacks of gall bladder colic. In 1950 a nonfunctioning gall bladder was demonstrated by x-ray. Shortly after the present admission, the patient developed severe right upper quadrant pain. Examination revealed his temperature to be 100 rectally. The pulse rate was 160, and respirations 30. The white blood cell count was 12,000 with 84 per cent polys. Lips were cyanotic and neck veins were full. There was diffuse

abdominal distention with severe right upper quadrant tenderness and rebound tenderness. X-rays showed right lower atelectasis in addition to the left lower lobe pneumonia and cardiac enlargement. Two days later his temperature returned to normal, and symptomatically he was much improved. However, there was persistent localized right upper quadrant tenderness. On the following day under local anesthesia a perforated gangrenous gall bladder was drained. There was a subhepatic abscess, containing approximately 90 cc. of bile stained pus. He has had several cerebral vascular accidents since the operation, and is now showing definite signs of mental degeneration. His appetite and digestion remain good.

Comment: It is obvious that this patient had had many attacks of gall bladder colic, but because of the reluctance to seek surgery, the operation had to be performed under the worst possible conditions. The improvement in his vital signs and his clinical appearance did not reflect the severity of the local condition in the gall bladder. This has been shown in the literature many times,³ and is also demonstrated in the following case.

CASE II

A 66 year old, retired grocery man was admitted to the hospital following abdominal cramps and fever of three days'

duration. His past history revealed that he had had an attack of right upper quadrant pain four months ago which required an hypodermic injection. Physical examination revealed upper abdominal tenderness and spasm. The temperature was 103, the pulse, 110. The white blood count was 21,000. X-ray examination revealed absence of gas in the left colon, and a question of a large bowel obstruction because of the distention of the right colon. While awaiting further study the patient was treated with gastric suction, Demerol, and atropine, and penicillin and streptomycin. The temperature came down to 101°F., the pulse to 80 and the pain and tenderness diminished. Suddenly, 36 hours after admission, the patient developed excruciating abdominal pain which was not accompanied by rising temperature. At operation a perforated gangrenous gall bladder was removed. Bile was found in all quadrants of the abdomen. Culture of the peritoneal contents showed no growth and the postoperative course was uneventful.

Comment: Essentially the management of this patient was that recommended by those who advocate delayed treatment of acute cholecystitis. The improvement in his vital signs and clinical appearance gave the physician a feeling of false security, which was abruptly shattered by the sudden increase in the patient's pain. Early cholecystectomy, often within the first 24 hours of hospital admission, will save these patients a prolonged stay in the hospital, and the added risk of a generalized peritoneal infection. The fact that the signs and symptoms in acute cholecystitis do not reflect the severity of the pathological findings has been emphasized by many writers. Gangrene and perforation may occur while the patient is under observation, and can be entirely missed by the most astute observer. The following case is an example of such a course.

CASE III

A 78 year old widow was admitted to the hospital because of right upper quadrant pain of ten days' duration. The past history revealed that eight years ago an emergency appendectomy was performed under local anesthesia because of severe heart disease. One month ago she was admitted to another hospital because of repeated attacks of right upper quadrant pain. On admission to that hospital the gall bladder was palpable, and its diseased state was confirmed by x-ray. During her stay, however, the pain suddenly disappeared and the gall bladder was suddenly no longer palpable. The patient was discharged without operation. On admission to Milford Hospital her temperature was 99.8 rectally, pulse 80, respirations 20. There was slight cardiac enlargement and a few rales at both bases. In the right upper quadrant there was a tender mass about five centimeters in diameter. The liver was enlarged three finger breadths below the costal margin. The blood leucocyte count was 14,000 with 73 per cent polys. The day following admission a cholecystectomy was performed. A pericholecystic abscess was found, which communicated through a perforation in the peritoneum, with an abscess in the rectus sheath and in

the subcutaneous fat. Culture of the abscess showed no growth.

Comment: Although in the above case the cardiac complication was not as severe as it was originally thought to be, it does on occasions present a very definite problem.

CASE IV

A 75 year old widow was admitted to the hospital because of severe chest pain. Nine years ago x-rays showed a poorly functioning gall bladder. A year and a half ago EKG showed an acute coronary occlusion. EKG taken on this present admission showed a recent anterior myocardial infarction. As part of her workup her physician also ordered a gall bladder series, which again showed a poorly functioning gall bladder. The day following x-ray examination the patient developed very severe right upper quadrant pain. Physical examination revealed an enlarged gall bladder with direct and rebound right upper quadrant tenderness. The temperature was 99, and white blood cell count was 6200 with 48 per cent polys. The next day her temperature rose to 101 and the patient appeared much more severely ill. Despite the anxiety of the cardiologist, it was decided that the gall bladder should at least be drained. This was done under local anesthesia. The organ was found to be gangrenous in two areas, but there was no evidence of perforation. The patient convalesced from her operation and from the acute coronary occlusion simultaneously, and has had no symptoms referable to the GI tract for a year after operation.

Comment: A simultaneous occurrence of acute coronary occlusion and acute cholecystitis is certainly unusual. The fact that the gall bladder attack came on the day after oral cholecystogram presents the interesting possibility that the fatty meal may have initiated the acute attack.

Particularly in the aged, the temperature, pulse, blood count and response to antibiotics is extremely misleading. The following case represents an instance of acute cholecystitis without clinical or laboratory evidence of infection.

CASE V

A 78 year old widow was admitted to the hospital because of upper abdominal pain, nausea and vomiting of four months' duration. The blood count, vital signs and abdominal examination were all essentially within normal limits. Oral cholecystogram showed a nonfunctioning gall bladder. The patient was discharged home by her physician, but returned to the hospital the same day because of severe upper abdominal pain. She was explored the following day and a large stone was found in the common duct. The gall bladder did not contain calculi and appeared to be thin walled. Pathological diagnosis, however, was acute cholecystitis.

Comment: Rupture of the acutely inflamed gall bladder is considered by some surgeons to be a rare occurrence. Furthermore, it is argued that a per-

forated gall bladder tends to wall itself off and the infection remains localized. No lesser a person than Ogilvie⁴ stated in 1950 that he had never seen a case of acute cholecystitis in which the gall bladder burst, nor had he heard of one in the wards of the hospitals in which he had worked for forty years. The cases presented above represent the more unusual types of acute cholecystitis observed in a year and a half among the aged admitted to a small hospital. The clinical findings do not at all parallel the severity of the local pathology. The surgeon may be misled because of the clinical improvement of the patient and the subsidence of the fever and physical signs under medical management.

In 1950 Ross⁵ questioned 151 highly qualified surgeons with regard to the treatment of acute cholecystitis. Most of them agreed on a cooling off period of from four to twelve days after the onset of illness. It is the contention here that such a period may be too long, particularly in the aged. It must be realized that a good number of these senile patients will stubbornly defer medical advice until the last minute, and thus when admitted to the hospital, the disease may have already progressed for from 3 to 7 days.

CONCLUSIONS

1. Diseases of the biliary tract are the commonest reasons for abdominal surgery in the aged.
2. Most of these older patients who have acute cholecystitis have had repeated attacks earlier in their life span.

3. Perforation of the gall bladder usually occurs three to four days after the onset of symptoms of acute cholecystitis.

4. There is no apparent correlation between the clinical appearance of the patient, laboratory findings, and pathological status of the gall bladder. There are no pathognomonic signs, symptoms or laboratory findings indicative of perforation of the gall bladder. In most instances rupture occurs insidiously and the preoperative diagnosis is not made.

5. Acute cholecystitis in the aged should be operated on within twenty-four to forty-eight hours after admission to the hospital.

6. Vigorous treatment with antibiotics does not defer a local perforation of a gangrenous gall bladder, even though it may improve the general clinical appearance of the patient.

7. Early cholecystectomy is the treatment of choice for acute cholecystitis in the aged. In a few cases cholecystostomy is a useful procedure, although it should be considered only a temporary cure.

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THE ROLE OF THE PSYCHIATRIST IN A TUBERCULOSIS HOSPITAL

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THE progress made in the prevention and treatment of tuberculosis during the past few decades, and especially in the last few years, is apparent to everyone. The long waiting lists have disappeared; indeed, in a few areas a surplus of facilities is beginning to exist. Tuberculosis nevertheless remains the No. 1 killer of the younger and middle age group and we may expect to have this disease with us for a long time to come.

THE TUBERCULOUS PATIENT AS AN INDIVIDUAL

Although the new pharmacological and antibiotic approaches to tuberculosis have started a progression of therapies which is constantly being augmented and improved, the understanding of the personalities and psyche of the tuberculous patient continues to present many problems. For a long time to come it will be necessary to consider the emotional adjustment of the people who contract tuberculosis. If a patient will only cooperate long enough, our medicine and our surgery will cure most of them.

We must concern ourselves with the personal problems our patients have left behind and the ones they have brought in with them. Help must also be available in preparing them for leaving the hospital into an independent existence again. Only in this way will it be possible to consolidate the gains made in the strictly physiological fields. It is common knowledge that it takes more than a tubercle bacillus to produce tuberculosis. Certainly, among the many vectors which lead to active illness, the psychological ones cannot be omitted.

Tuberculosis is considered by many to be a psychosomatic disease. The great teacher, Sir William Osler, emphasized that the progress of the tuberculous patient depended more on what was going on in his mind than what was in his chest.

Wittkower has put it a bit differently when he said that sometimes it may be safer to judge a patient's prognosis on the basis of his personality and

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SUMMARY

The more one works with the tuberculous individual, the more one is impressed by the psychological factors. Most of the males in a group of almost 500 patients that were studied at Uncas-on-Thames Sanatorium, fell into a personality pattern which bordered close to the psychopathic. The adjustment to illness, the attitude to surgery, the very outcome of the disease process itself, are reflections of certain psychological forces. Efforts must be made to keep recalcitrant patients in the sanatorium long enough to effect a cure, thereby interrupting the contagious cycle.

his emotional conflicts than on the basis of his x-ray film. The prevalent attitude that tuberculosis may be arrested but never cured, sets up a pessimistic mental state which must be attacked at the very outset, in order to stimulate the patient's full interest in his own recovery.

The psychiatrist, therefore, has a very fertile field to plow. Today I would like to tell you of some of the ways in which this psychiatric relationship can function in a tuberculosis hospital.

The patients being specifically considered in this study consist of those admitted to Uncas-on-Thames Sanatorium, Norwich, Connecticut, during a one year period from September 1, 1952 to August 30, 1953. Of a total of 462 patients, 336 were men and 126 were women. The sex difference is strikingly significant. These patients were rechecked one year following their admission to establish which ones had been discharged with advice, which had left against advice, how many had died, etc.

Our results showed that of the total of 462 patients, 108 were still under treatment at the hospital, which is a reflection of their good adjustment.

DISCHARGED AGAINST ADVICE

Thirty-one had expired in the hospital and 238 had left with consent. Only 85 or 18 per cent of those admitted during the year under consideration had left against medical advice. I have reviewed the literature to learn the experiences of other clinics as far as irregular discharges are concerned. An analysis of all these statistics produced a figure just under 50 per cent. Our own results mentioned above represent, therefore, an appreciable decrease in the number of patients who leave the hospital before optimum benefit has been derived. Many factors contributed to this favorable result, not the least of which was the exemplary understanding of the medical staff and the high caliber of positive directed therapy. There can be no question that a connection exists between the satisfaction and cooperation of the patient and the degree of morale in any given institution. In this total picture of hospital morale the psychiatrist has a most important role to play.

In dealing with the patients at our hospital, one was forced to wonder if it were a hospital for tuberculosis patients, or whether we had not wandered into an institution for inadequate male psychopaths. I stress male because the female population made up only 27 per cent of the total admissions; they also appeared to be entirely different in their personality structure than the males. Sixty-three per cent of the male patients, whose average age was 50, were single, separated or divorced. Only 121, or 37 per cent were married and living with their spouses.

One hundred and thirty-six or 40 per cent could be classified as problem drinkers. Most of them had spent some time in jail because of their drinking habits. As a rule they kept to themselves and lived by themselves in rooming houses, with no strong family ties. Only relatively few of the men were gainfully and steadily employed before they became sick.

It was obvious that we were dealing for the most part with an inferior group. Before they had become ill they had been parasites of society. Now that they had contracted tuberculosis, they had become a more serious menace to society. Most of these people were working as cooks, dish washers and in other vulnerable spots. It was probably this group

more than any other that was preventing our splendid record of eradicating tuberculosis from being considerably better. There is a pressing obligation to keep them under treatment in a hospital in order to interrupt the vicious cycle of contamination and contagion.

In order to cope with this problem of irregular discharges, some states have decided to resort to compulsory isolation. In the State of Washington locked wards have been produced for those patients who are in a contagious state and who refuse to accept treatment voluntarily. It may be argued that this is a step in the right direction; taking into account the psychiatric factors, these patients are considered to be mentally too irresponsible to be permitted free. I am afraid the reaction of those individuals must be that they are simply being jailed and punished. Their regard for society and their behavior following their release cannot be improved by this type of custodial treatment.

THE INITIAL INTERVIEW

It was our practice to interview each new patient about one week after his admission to the hospital, after he had had some time to adapt himself. The interview was informal, followed no set scheme, but was conducted in the examiner's office in complete privacy. His feelings about the hospital and his illness, his previous work record and habits, and his plans for the future were all discussed. An attempt was made to evaluate how this person would react to any new stresses. Some note was made of his educational history and his emotional maturity. This information was noted in the patient's record for the orientation of the ward physician, who had to work with the patient every day.

It was explained to the patient that the staff of the hospital was interested in him as a whole, not only in his specific illness; that he could discuss his problems, questions, fears and complaints with the physician in complete privacy at any time. It was made obvious to him that he alone was not selected for this interview, but that it was a service offered to every patient. He was told of the various social service and rehabilitation agencies which were also available to help him with the general problems of his living, while other people were curing his tuberculosis.

THE MATURE GROUP

I have stressed that a great majority of our patients, especially the males, are unstable and inade-

quate people. There remains a group, however, who were apparently fairly mature and adjusted before becoming actively ill with tuberculosis. It is in this group that we find at first considerable reactive depression. This is inevitable as, in many cases, there was little forewarning before this great catastrophe struck. Separation from children, husband or wife immediately causes concern, which then leads to anxiety and doubt. Will the loved one be faithful and understanding the long period of cure? What will be the effect on the sexual and social drives of the sick patient and the spouse? How will the family manage financially? These are real questions which every one must ask himself. It is in this area, too, that the psychiatrist has an important psychotherapeutic function.

In the privacy of the psychiatrist's office these patients can express their doubts and fears better, receiving the benefit of cathartic effect. Often, when their problems are known, some practical solutions can be reached. It helps greatly for them to realize that someone is interested in their questions and to be told that their problems are not at all unique and a sign of their own inadequacy, but a common and expected reaction to an unusual situation.

As a result of this approach none of the patients (except the few true paranoid ones) developed any sensitivity over being given a psychiatric examination. It was much easier to interview these patients again if certain points required clarification after the first examination. Many took advantage of the psychiatrist's suggestion that they ask for an interview if they became nervous, or could not sleep, or became discouraged with their progress. In this way a fair number of incipient psychoses were picked up early, I believe, at least a few suicides prevented which otherwise might have occurred.

As John Richman pointed out in the introduction to Dr. Wittkower's most valuable book "A Psychiatrist Looks at Tuberculosis," it must be borne in mind that the psychiatric interview is a two way process, leading to a sort of self discovery. If the patient does not get a deeper understanding of himself and his condition after an interview with a psychiatrist, then that interview has failed in one of its purposes, however much it may seem to have contributed to the doctor's knowledge. Incidentally, the unconcerned or euphoric person, the "spec phthistica" so frequently referred to in the literature, was noticeable only by his complete absence.

Today most people are aware of the mind-body interdependence. It is helpful to point out to a patient with tuberculosis that a proper attitude about his illness, expressing his fears and freeing himself from anxiety concerning it, can have a direct effect on the rate of his cure. Some of the responsibility for his improvement is placed directly on him. He feels less helpless and passive in this whole process of recovery. It is through this type of psychotherapeutic relationship that a psychiatrist does his most fruitful work at a tuberculosis hospital.

FEAR OF SURGERY

As greater emphasis is placed on the surgical approach in tuberculosis therapy, various emotional implications result. Dunbar, in particular, has described the personality of the tuberculosis patient as being primarily obsessive-compulsive in type. We are dealing with a type of person where anxiety, dependence and autistic thinking prevails. This results in a fear of surgery which overweighs the desire to be rid of the dread disease. For many of the cases surgery may be the only answer, for we know a good number of our patients will not remain in the hospital long enough to obtain maximum benefits from orthodox, conservative therapy.

These are difficult people to handle; investigation has revealed that either repressed, severe, aggressive drives or a deep sense of guilt have led to this fear of self mutilation. In certain instances brief psychotherapy has produced enough insight and catharsis to permit the necessary surgery to be performed.

There is another group of patients whose general health continues to fail even though they seem to be handling their tuberculosis well and, according to all objective criteria, they should be getting better. There is no fever, the lesions have cleared, the sputum is negative, and yet the course is down hill. I believe that thorough investigation would reveal in these people depressive phenomena with repressed aggressive drives leading to feelings of guilt. It is as if one says to himself: "One method has failed and I am told I am getting well. This cannot be. I must find an alternative way of destroying myself." Such reaction forms are found in many of the patients a psychiatrist must deal with. It may well be the very core of what we call neurosis. Applying the psychotherapeutic art to this type of tuberculosis patient should bear fruit in a good many instances.

CONCLUSION

The average male tuberculosis patient in the State Sanatorium being considered here appears to be an inadequate psychopath, who is either single or separated from his wife, addicted to alcoholism, and if he works at all it is at a job which makes it easy for him to spread his disease to others. It is therefore obvious that if one attempts to treat the tuberculosis without regard to the basic personality profile, neither the individual nor society will eventually benefit. In addition, even to the most normal person, the emotional and practical upheaval which results from facing a long period of treatment with uncertain outcome, while separated from his loved

ones, cannot help but create confusion and depression.

The transference relationship and insight which a psychiatrist can provide, should make him an essential member of the medical team. He is in a position to advise the rest of the medical staff, and to act as a buffer between the staff and the patient, permitting him to express his anxieties and his hostility in a relatively neutral environment. It is this approach which recognizes the reality of the psychological as well as the somatic factors in tuberculosis. It has made it possible to have a larger number of patient cures in the hospital over a longer period of time. The advantages to the individual and to society should be obvious.

FLARING OF THE RIBS ASSOCIATED WITH OTHER SKELETAL ANOMALIES

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EXTENSIVE use of chest radiography in the last 25 years has revealed some interesting congenital anomalies of the thoracic cage; the incidence of these anomalies was not found to be a negligible one. Most of the early observations were made abroad but in recent years the different types of congenital anomalies of the thoracic cage have been studied extensively in this country.

Comprehensive review of the literature of the last 25 years reveals general agreement among several reports as to the incidence of these anomalies. It was found to be approximately one per cent in large series of routine chest roentgenograms.^{1,2} The most common types of anomalies of the ribs observed are: cervical; bifid; synostosis; rudimentary; in particular the first ribs; anomalous first rib; flaring of one or two ribs; and bridging of two ribs.³ Usually these osseous anomalies are asymptomatic and are observed only coincidentally on chest films taken for other reasons. Cervical ribs, however, are sometimes asso-

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SUMMARY

The incidence of congenital abnormalities of the thoracic cage are briefly discussed.

A unique case of rib deformities associated with other skeletal anomalies is presented.

Embryonic development of the ribs and a general discussion of genetic factors and nongenetic factors causing congenital anomalies are presented.

ciated with symptoms giving rise to the scalenus anticus syndrome.^{4,5}

Bifid ribs and synostosis of two ribs are seen more

often while other anomalies occur with less frequency. Flaring of the sternal end and bifurcation of one or two ribs, known as Luschka's deformity, is considered a rare abnormality, and diffuse flaring or widening of one rib, most often the first, in its entire length is even rarer. Generalized widening of all 24 ribs has not been previously reported, and for this reason we consider it worthwhile to present the case, particularly since other associated skeletal anomalies make the case even more unusual.^{6,7,8,9,10}

CASE REPORT

Twenty-one year old Puerto Rican girl admitted to Metropolitan Hospital, New York, N. Y. on November 6, 1953, complaining of severe temporal headache and sore throat of two days' duration. Prior to the onset of present illness she was in good health. Physical examination and laboratory studies suggested the diagnosis of meningococcal meningitis and she responded well to treatment with sulfadiazine.

The patient was the fifth of six children who were entirely normal. This child was delivered normally and there were no German measles or other diseases during this pregnancy. The mother is a school teacher and states that the girl is of normal intelligence and attended school through the 9th grade. In the family history, including the maternal and paternal grandparents, there are no known skeletal defects. The patient had an unknown type of operation for bilateral club foot in infancy.

The following interesting features were noted besides the symptoms and signs of her acute infection: Height was 4 feet 8½ inches, weight 80 lbs. and span, 4 feet 9 inches. There was normal hair distribution, and pronounced dorsal and lumbar lordosis. There was slight tilting of the pelvis with the left crest higher than the right. Marked flexor contracture of the metacarpal phalangeal joints and extensor contracture of the interphalangeal joints of both thumbs was present. There was a widened interspace between the index and middle fingers of both hands. The hallux of both feet pointed laterally and the toes medially resembling a metatarsus varus. No typical club foot deformity was present.

X-RAY REPORT — CHEST

Chest film shows moderate scoliosis of the dorsal spine with the convexity to the left. The ribs on both sides from the third rib down show fusiform-widening of the posterior segment while the anterior portions of the ribs are normal. The heart and lungs are within normal limits (Figure 1).

RIGHT FOOT

The proximal phalanx of the right great toe shows a marked reduction in size with partial fusion to the distal phalanx noted. There are some flat exostosis in the third, fourth, and fifth metatarsals. The tarsal bones are definitely smaller than normal and show partial fusion. There is thickening and coarsening of the trabeculi. Several loose oval shaped calcifications are seen just distal to the medial malleolus (Figure 2).



FIGURE 1



FIGURE 2

LEFT FOOT

Also shows multiple flat exostoses involving the second, third, fourth and fifth metatarsals. Because of these exostoses

between the second and third toes, there is a V-shaped deformity involving metatarsals. As on the right, the tarsal bones show fusion with coarsening and thickening of the trabeculi.

BOTH HANDS

The thumbs of both hands show a definite deformity in which the phalanges are at right angles with the first metacarpals angulating towards the ulnar side (Figure 3).



FIGURE 3

DISCUSSION

In the normal process of development of the embryo the primitive mesoderm of each somite is differentiated into the sclerotome. From the sclerotome the vertebra is developed and the rib is derived as an outgrowth of the developing vertebra.¹¹ Ossification of the ribs begins in the so-called first center; at a later stage ossification continues at a faster rate than in the accompanying center. Finally, the period of osseous construction becomes similar to that of the body segment of which the rib is a part.¹² In congenital malformations of the ribs the process of differentiation and development is disturbed by either genetic or nongenetic factors.

Congenital malformations in general may be due to damage during fetal life (exogenous) or to endogenous, that is, genetic factors. Among the intra-uterine influences, the mechanical factors as pressure

of the uterus, amnion bands and threads, etc., formerly considered highly important, play only a minor role according to modern concepts.¹³ They can be excluded in our case since pregnancy, birth, and the amount of amniotic fluid were normal, and secondly, because the strictly symmetrical deformities of the ribs cannot be explained by mechanical effects during intra-uterine life.

The most important exogenous causes of congenital malformations during early pregnancy are exposure to radiation or virus infection, in particular, German measles of the mother during pregnancy.¹⁴ It may be mentioned, however, that these factors by virtue of their pathogenetic mechanism form a transition to the endogenous causes of deformities, inasmuch as they cause a damage in the genotype altering its effect on the organism. A sudden change of a gene or a group of genes in the germ cells is called a mutation. It is not inherited since it constitutes a new formation of a gene, but it is passed on to future generations according to the laws of heredity; it is inheritable. Such mutations occur spontaneously in the population, but they can also be produced by irradiation. Moreover, irradiation during early pregnancy, as well as German measles of the mother in this period, may cause a similar genetic damage in the somatic cells of the early fetus, a so-called somatic mutation. Such a damage leads to malformations of the child which, however, are neither inherited nor inheritable since they do not concern the germ cells. Mutations due to actinic damage do not differ otherwise from spontaneous ones. In our case neither irradiation nor a virus infection of the mother was implicated.^{15,16,17}

Having excluded the exogenous causes of malformation in our patient, it seems most probable that endogenous genetic factors are responsible for the deformities observed. We have to admit that the case does not offer a definite proof for this assumption even though the family history was entirely negative as to bone and joint disorders. Such a negative history, however, does not militate against our theory since, firstly, our data unfortunately are only anamnestic ones, and we were not able to examine the other members of the family clinically or radiographically. It is obvious that rib anomalies may have been present but not detected without x-ray studies. Secondly, in agreement with the laws of genetics, an hereditary character, following the

so-called recessive mode of inheritance, may run in a family through many generations in a latent manner until it becomes manifest by mating of two individuals, both of whom possess this character in a latent state. Finally, as mentioned above, a spontaneous mutation may have occurred.

The theory of a genetic cause of this peculiar rib anomaly is further supported by its combination with other deformities of the bone-joint system in whose etiology genetic factors are known to play a part. According to the past history we must assume that the patient had bilateral congenital clubfoot which later was partly corrected by operation. It is now generally accepted that genetic factors play an important part in the etiology of clubfoot. Furthermore, one of the authors showed that most of the rarer congenital joint contractures, as those of the thumbs of our patient, have a genetic origin.¹⁸ Howorth¹⁹ stresses that hereditary factors not infrequently play a role in the etiology of congenital contractures of joints.

In view of all these facts we consider it highly probable that the syndrome of skeletal anomalies and in particular the deformity of the ribs first observed in this case are due to genetic factors.

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THE YALE PLAN OF MEDICAL EDUCATION AFTER THIRTY YEARS

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A PLAN of study which differs in many respects from that followed in other American medical schools has been in operation at Yale since the mid-twenties. At the time of its inception it aroused a good deal of interest and now, when several new schools are being established and others are revising their teaching programs, interest in it has been renewed. This time, therefore, appears to be an appropriate occasion for review of the plan and a description of its evolution after the first 30 years.

To understand its origin one must consider the climate into which the program was introduced. During the first quarter of the 20th century, medical education in the United States was undergoing a dramatic upheaval. Many hospital schools, operated essentially as vocational schools, closed their doors and others became more directly responsible to their parent universities. The course of study was increased to four years and, of greater significance, preliminary instruction in the natural sciences was inserted without any serious effort to coordinate it with the medical program.

The result of these simultaneous changes was that many medical schools were suddenly transformed from undergraduate vocational colleges to graduate schools, but the methods of instruction remained at the undergraduate level. In some schools, grammar school methods predominated. Daily recitations were based on textbook assignments; lecture notes were memorized and regurgitated during weekly examinations; laboratory experiments were performed from manuals, with the principal goal a neat report rather than an understanding of the physiological mechanism they were expected to demonstrate; special interests and initiative to explore original ideas were discouraged by rigid schedules which permitted no time for independent thought.

The Yale University School of Medicine, during this period, was entering the second century of its existence and an era of extensive reorganization. More adequate financial resources had become available, a full-time faculty was appointed in the clinical departments and new buildings were under construction. The atmosphere was such that the faculty was more than usually receptive to adjustments in organization and attitudes and the students were less than usually resistant to new methods of study. It was under these circumstances that the faculty had the courage to introduce a program in which the medical student was treated as a graduate student and given more than customary responsibility for his own development.

An adequate understanding of the philosophy and objectives of the authors of this program can be obtained by reading the classic review written by Dr. Samuel C. Harvey in 1941, after it had been in operation for approximately 15 years.¹ Dr. Harvey emphasized that the effectiveness of an educational program in medicine is dependent upon the extent to which these desirable qualities of a physician are strengthened: integrity, intelligence, capacity for work, common sense and a faculty of ascertaining the truth.

In discussing integrity, he observes that the medical student is an adult, particularly in respect to underlying qualities of behavior and conduct, and that any changes which may occur, for better or for worse, will result from the example set by members of the medical profession within and without the faculty. With this consideration in view, a cordial relationship between students and faculty has been encouraged and experience has shown that it can be fostered by work in small groups rather than by more formal methods of instruction.

Little can be done to alter intelligence. It has been the intention of the faculty to admit only students of adequate intelligence and to aid them in using

their native talents to advantage by indoctrination in good learning habits.

Dr. Harvey observes that "lack of initiative and the absence of a sufficiently demanding intellectual curiosity is responsible for more poor practice of medicine than any other one thing." He is severely critical of enforced performance through enforced attendance, controlled systematic coverage of material, frequent checking by examinations and absurd mathematical evaluation of achievement, and he concludes that "work so done by command and rote, and so checked, destroys initiative and makes by these associations intellectual work disagreeable." Capacity and enthusiasm for intellectual work perhaps have been the qualities most stimulated by this program because, in comparison with the other qualities under consideration, they are more susceptible to development in this age group.

The fourth quality—common sense—like intelligence cannot be influenced to any considerable degree by instruction, although "when derived from a properly proportioned integration of one's knowledge and experience, it is of greatest importance." It seems redundant to add that the student who is constantly under pressure in the lecture hall and recitation room to memorize facts in anticipation of the next examination has little time or inclination to develop this essential quality.

The faculty for ascertaining the truth is as essential in the clinic as it is in the laboratory and "the ideal physician is not one who has a content of knowledge of a certain vintage, but one who has that of the present moment critically evaluated." His problems are those which can be solved only by the scientific method and he should, during his training, have daily experience in using it. It is not difficult to understand why a faculty which accepted this concept has insisted over the years that every student carry out an original investigation—not primarily for the purpose of adding to scientific knowledge, but rather to give him an experience which will make him a better physician.

No educational program worth its salt ever has or ever will be in final form. To be effective, it must be subjected to constant evaluation and improvement. Reappraisal is especially indicated at those intervals in the life of a school when retirements lead to appointment of new leaders who may view existing methods with skepticism or lack of understanding. If they accept an existing program, with

enough modifications to give them some sense of parenthood, it will go forward. If they reject it, they are at least under obligation to produce a better one.

Our faculty, having experienced a change in most of its departmental chairmen during the past few years, recently took a fresh look at the "Yale plan" and after minor modifications designed to make it more effective, came to the conclusion that it offers the student an educational experience not to be obtained under the more orthodox systems of instruction.

The basic philosophy, as it is now understood, is summarized in the following quotation from the faculty committee's report:

"Fundamental to this program is the concept that the medical student is a mature individual, is strongly motivated to learn and requires guidance and stimulation rather than compulsion or competition for relative standing in his group. Equally basic is the concept that if the student is given unusual privileges, he must assume more than usual responsibility for his education."

It should be recalled that it was the aim of the founders of this plan to create an atmosphere favorable for learning rather than a unique curriculum. They would probably have challenged anyone's ability to define its methods precisely. Over the years, however, certain characteristics which distinguish the methods of instruction from those of most other medical schools have become apparent, and it is the purpose of this report to define these characteristics rather than to dilate further on the underlying philosophy of the program. They are (1) the required dissertation, (2) lack of fixed course requirements for qualified students, (3) emphasis on elective courses and (4) absence of required course examinations.

THE REQUIRED DISSERTATION

Although research by students is encouraged at some other medical schools, at no other American school is the presentation of a dissertation, based on original investigation, one of the requirements for the M.D. degree. Each student, by the middle of his first clinical year at the latest, presents an original hypothesis and plan of attack to the faculty member under whom he chooses to work. From that point on, facilities and guidance in pursuit of the answer to his problem are provided in exactly the same manner as they would be for any other graduate

student. He has a corner in a laboratory which he can call his own and he works there during free periods, weekends and often over one or two summer vacations. Often he establishes a close relationship with other members of the department, attends the departmental seminars and considers the laboratory the home base of his operations.

The quality of dissertation presented at the end of this experience varies widely. Many, perhaps 10 per cent over the years, would be acceptable to the same preclinical department if presented by its candidates for the PH.D. degree. At the other extreme, some of the studies are quite superficial. In every instance, however, the student has explored the literature in a field of knowledge, has formulated an hypothesis, has worked out a method of approach, has carried out the necessary experiments, has reached a conclusion and has written an acceptable report.

It has been argued repeatedly that it is a waste of time for the prospective practitioner to engage in research and that his time as a medical student would be spent more advantageously seeing more patients. The contention of the Yale faculty is that as a result of this experience a few students will have had kindled the spark of curiosity which will lead them to a career in academic medicine and many others will become better practitioners. The four-year period as a medical student is the time to develop attitudes and to gain basic knowledge. Experience in dealing with large numbers of patients will come later.

LACK OF FIXED COURSE REQUIREMENTS

Students who by virtue of previous experience can demonstrate competence in the field of knowledge covered by a course are encouraged to accept special assignments such as participation in instruction or research in the field, or are excused from attendance and given additional time for elective work.

This arrangement makes it possible for students who have obtained advanced degrees in the medical sciences to fit into the medical curriculum without going through the motions of repeating courses. Students are encouraged to study at other universities, to accept fellowships for advanced study and research without feeling that they must keep in lock-step with the other members of a class. There is nothing very mysterious about this arrangement. It merely means that students are treated as individuals.

A serious effort is made to discover and develop the exceptional student. Since the major handicap for many who may wish to spend a longer time than usual in medical school is a financial one, some of the general research funds are used to provide fellowships for a year of concentrated research activity, preferably between the preclinical and clinical years. Fellowships are also provided to cover living expenses of those who have demonstrated an interest and capacity for investigative work but could otherwise not afford to remain in residence during the summer vacations.

EMPHASIS ON ELECTIVE COURSES

It has been a basic policy in this program that the student should not be under such pressure to attend required exercises from eight to five daily for four years that he has no time for pursuit of special interests. For that reason, there are fewer than the usual scheduled hours in the curriculum. The student may choose to attend several electives or none, and he receives no credit. The man who learns slowly may feel that his time is spent most effectively by additional study in the basic courses. The brilliant student does not feel confined to the pace of the slower learner.

Elective courses offered follow four patterns. Many are in the form of seminars, attended by faculty members and other graduate students. The groups are small and active participation is encouraged. The general conference type such as the tumor clinic, the neurological study unit and the clinical-pathological conference is organized on an interdepartmental basis and provides one of the most effective means of integration. Laboratory courses such as one in topographic and cross-section anatomy provide an opportunity for advanced laboratory experience. In the clinical electives the student who develops a strong interest in children's neurology or hypertension or metabolism, for example, may be assigned to the appropriate clinic for a period of several weeks.

Without doubt, some of these elective courses are confined to highly specialized areas, and it may be said that the undergraduate medical student is not ready for such an experience and should confine his interest to basic material. It cannot be denied, however, that intimate contact with a faculty member or group whose investigative interests have carried them into a limited field is an exciting experience for a student, and we believe that he should be excited as well as taught.

One of the problems involved in presenting an effective elective program is that of scheduling, and our faculty is now engaged in a rearrangement of the schedule which should lead to better results. Conflicts between popular elective and basic work have been irritating to the faculty and have led students to neglect responsibilities. To make an elective program most effective, there should be open hours common to the schedules for the four years as well as free periods in each year for concentrated attention to research and study outside of the basic courses. Another situation to be guarded against is that of inclusion of essentially basic material in elective courses as a means of capturing more of the student's time. This leads to development of "required electives" which the student feels compelled to attend and to destruction of the entire elective program.

ABSENCE OF REQUIRED EXAMINATIONS

With the exception of lectures in the preclinical courses, designed to orient the student and discuss topics not covered in textbooks and daily assembled clinics in the clinical years, instruction is carried out in small groups in the laboratories, conference rooms, wards and outpatient clinics. Under this method of instruction, evaluation of achievement can be dependent primarily on the intimate acquaintance of faculty members with each student and their appraisal of his progress. Frequent examinations are not only undesirable but are unnecessary.

During the preclinical years, examinations are offered on a voluntary basis two or three times during each course to aid the student in review and self evaluation. The papers are corrected but not graded and are discussed at group conferences.

A tutorial plan has been introduced during the current year in the departments of pediatrics and medicine. During the period of his ward clerkship in these departments each student is assigned to a member of the faculty with whom he confers at weekly intervals. These conferences, which are very informal, may take the form of discussion of a patient or clinical problem or theory, or may involve a walk around a ward. The student is guided in his reading and aided in understanding subjects he has failed to master.

At the end of each course, a narrative report, representing the composite opinion of the department, is submitted on each student. These reports are reviewed periodically by progress committees

appointed for each year. The purpose of these committees is not to formulate grades or class standings but to help the student who is found to be falling behind in several courses.

The only formal examinations are those of the National Board of Medical Examiners. The student may present himself for Part I, covering preclinical subjects, after not less than two or more than three years, and for Part II, covering clinical medicine, within the same interval. Successful completion of the national board examinations is the threshold requirement for advancement from the preclinical to the clinical years and for graduation. Final decision as to the student's progress and the award of honors and prizes, however, is made by the board of permanent officers, comprised of all full professors, on recommendation of the four class progress committees.

This report is not written with any expectation that the Yale plan will be adopted in toto by other schools but rather with the hope that at this time when medical education is again in a state of ferment, others may benefit from our experience. In many respects the plan may not have worked out as originally intended. This is merely a description of the state of evolution of the program after 30 years, including some revisions made during the past year.

Let me repeat that there is nothing unique or ingenious about it. The material covered is in most respects similar to that in other American medical schools and the methods of instruction are those which have been considered satisfactory in fields of graduate study other than medicine for centuries. The essential feature is that the faculty is concerned with guiding and stimulating a group of intelligent young men and women rather than in drilling and examining them.

One of the chronic problems has been the adjustment of entering students to a less restrictive atmosphere than they have encountered over the previous 16 years. Accustomed to definite assignments, didactic lectures, copious notes and frequent examinations, a few members of each class have been emotionally disturbed and insecure. This condition seldom continues beyond the middle of the first year and, with few exceptions, those who have completed the program are its most ardent supporters.

Probably a few uninspired students abuse the freedom inherent in this plan and would emerge from a more compulsive atmosphere with a larger

stock of factual knowledge. It is, admittedly, not designed for the mediocre man, but it is surprising how few of those selected for admission turn out to be really mediocre when challenged by the opportunity to assume responsibility for their own education. The temptation to "put it over on the faculty" loses its flavor when it is discovered that nothing is to be gained.

If one thing has been learned from this experiment over 30 years, it is that teachers and their attitudes are more important than curriculum structure and methods. There is much discussion about "integration," "comprehensive medicine" and "vertical" versus "horizontal" curricula. Unless the student is given an opportunity to think for himself, is given time for pursuit of special interests and, most important, is freed from frequent course examinations and constant attendance at didactic lectures and recitations, efforts at integration—vertical, horizontal or diagonal—are wasted. In this regard, the comments of a British colleague who visited several American schools during the past year will be of interest:

"There is a tendency everywhere, and perhaps particularly in America, to equate what is new with what is good, and to confuse the means with the end, especially where the means are striking and dramatic. The present trend is to concentrate on the teaching and to neglect the teacher, on the assumption that if only the right METHODS can be found all will be well. This seems to me to put the cart squarely in front of the horse. Given good teachers and good students, it does not matter much what passes between them; the product will also be good. Teaching is a thing done by individuals to individuals, and method must always be secondary. 'Sir,' said our old friend Dr. Johnson many years ago, 'it is no matter what you teach them first, any more than what leg you shall put into your breeches first'."²

The crucial test of any educational program is the quality of its products—impossible to determine immediately and not apparent in any degree of accuracy even after years. Absence of the pressure of frequent examinations has not seemed to influence unfavorably the amount of factual knowledge acquired because Yale's record in the national board examinations, the only available method of comparing students who have attended various schools, has been excellent. Reports indicate that our graduates are stimulating members of resident staffs, have a breadth of interest and social responsibility which makes them responsible general practitioners and enter specialty training or research with at least the usual amount of maturity. An unusually large proportion of the graduates over the life of this program have become teachers and investigators.* Whether this is a function of the methods of instruction or the type of student attracted, we do not know.

Yale's fundamental purpose is "the training of men by the cultivation of their individual powers of reason and conscience for the broadest possible responsibilities in our society."³ We believe this program has been successful to a considerable extent in the attainment of that goal.

*Yale stands third among the schools of the country in the per cent of graduates during the period 1925-1949 holding full-time faculty appointments in American medical schools. (Diehl, H. S., West, M. D. and Barclay, R. W.: *J. Med. Ed.*, 1952, 27, 309-315.)

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EDITORIALS

Science Registers A Victory

The year 1955 will take its place in history as marking one of science's major victories, the release to mankind of a vaccine proven to be effective against anterior poliomyelitis. To Dr. Jonas Salk goes the credit for perfecting this vaccine but one must not overlook the long list of scientists who contributed to this therapeutic victory. There was the demonstration in 1949 by Enders, Weller, and Robbins that poliomyelitis viruses not only multiply in tissue cultures but also produce a characteristic cytopathogenic change by which the presence of virus can be recognized. Connecticut has turned with pride to its own native son, Dr. John F. Enders, for his part in this discovery. Then came the demonstration by Bodian and the study by Freund which together made the outlook for artificial immunization against poliomyelitis in man more hopeful.

The present vaccine contains "killed" material obtained from each of the three antigenic viruses which has been found to induce in man as well as monkey the formation of type specific antibodies. These produce a postvaccinal resistance to infection with the homologous challenged virus, effective 80 to 90 per cent against the paralytic virus, 60 per cent against Type 1, and 70 to 80 per cent against Types 2 and 3.

The United States Government has set its approval on the Salk vaccine and the Secretary of Health, Education and Welfare has licensed six pharmaceutical houses to produce and market the vaccine through regular commercial channels. The

distribution of the vaccine will be carried out in Connecticut by the State Department of Health and the injections will be administered without charge to all pupils in the first four grades in the three counties of Hartford, Litchfield and Fairfield where the 1954 tests were carried out. Appropriations by the General Assembly will enable the program of inoculation to be expanded to a group of about 50,000 more which will include both children and pregnant women. In addition to these there will probably be available in a short time some vaccine for purchase and use by physicians in their private practice.

Already the cry is going up that the National Foundation for Infantile Paralysis, which has spent millions of dollars in aiding research in the prevention and treatment of poliomyelitis, should direct its funds and efforts into other fields, such as mental health. To the National Foundation should go a generous measure of praise and gratitude for the part it has played in making possible this last great scientific accomplishment. But this is only the beginning and much remains yet to be done. The important question yet to be answered is whether or not the postvaccinal "immunity" is permanent or only short lived. No one knows as yet just how long this artificial immunity will last, nor how often booster injections will be required to maintain an immunity. Dr. John R. Paul of Yale, when discussing this whole problem in the February, 1954 issue of the JOURNAL, raised the question "whether a single or multiple course of active immunizations with a 'killed' virus would merely postpone and not eliminate infection;" and "if the infection is merely

postponed, then immunization might even have to be repeated periodically for the rest of a person's life."

The medical profession rejoices with the public at large in the fact that the dread disease of polio-myelitis appears to be a candidate for that group of former enemies now almost entirely vanquished: typhoid fever, diphtheria, small pox, etc. Further research is needed to make a polio vaccine even more effective and to carry out a successful program of prevention. Towards these ends we continue to bend our efforts.

Blood Bank

The Connecticut Red Cross Regional Blood Program commenced operation in June 1950 and since that time sick people in Connecticut have received blood for transfusion in a practically unlimited amount without charge. Currently, the usage is 85,000 pints per year, supplied to all hospitals on the basis of about 12 pints per occupied bed. It is a community enterprise of the first magnitude and the Red Cross and others connected with it are deserving of the highest praise.

The blood itself is donated by generous, good citizens but its collection, processing and delivery is an expensive undertaking that costs \$400,000 a year in addition to uncounted thousands of hours of volunteer work. The program has been financed about equally by the National Red Cross and the Chapters in Connecticut and by thrifty management the cost per unit produced has been cut down so that the whole has been on an economical basis.

National Red Cross has given notice that its support is to be gradually withdrawn over a period of three years. At the end that time it will contribute only 75 per cent of the amount now supplied and the remainder of the cost of operation must come from elsewhere.

During the five years of the Bank's operation the blood has been free to the consumer. The patient has had to pay a service charge to the hospital where the blood was received and the amount of this has varied from hospital to hospital, but the Bank itself receives nothing from the patient.

Now, with the withdrawal of the part of support from National Red Cross, funds must be had from other sources. After careful analysis of the circumstances, the management of the program has decided that a part of the handling cost should be borne by

the recipient of the blood. The amount of this charge based upon the cost of the containers and the cost of delivery has been set at \$2.10 per unit. Efforts are being made to have the hospitals agree to add this sum to the patient's hospital bill and after it is paid, remit it to the Blood Bank.

Physicians should interest themselves in this new plan and give it their wholehearted support by explaining to their patients that this small charge is in no way to be considered as payment for donated blood they receive, the charge is simply a part of the cost of making blood available to them.

Elevation of Children's Bureau Recommended

It is very pleasing and most heartening to all concerned with the health and welfare of children to know that the Task Force on Federal Medical Services of the Hoover Commission has endorsed the integrity of the Children's Bureau. This Task Force is headed by Theodore G. Klumpp, a member of the Connecticut State Medical Society. Other members are Edwin L. Crosby, assistant chairman, Francis J. Braceland, also a member of this Society, Otto W. Brandhor, Edwin D. Churchill, Michael De Bakey, Evarts A. Graham, Alan Gregg, Paul R. Hawley, Hugh R. Leavell, Basil C. MacLean, Walter B. Martin, James Roscoe Miller, Dwight L. Wilbur, and Milton C. Winternitz, another member of our Society.

The Report (Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., price 40 cents) page 101, reads as follows:

The Children's Bureau is one of the few Federal agencies organized strictly on the basis of clientele. Founded in 1912 in a reform era, the Bureau has operated with dedication and with outstanding success. In 1946, when it was transferred from the Department of Labor to the Federal Security Agency (predecessor of the new Department), it was placed within the Social Security Administration.

We conclude that the Children's Bureau does not logically belong in the Social Security Administration for it has important duties outside the welfare field. On the other hand, the work of the Bureau has been so satisfactory and its focus on the whole child so desirable that its functions should not be split among other constituent agencies of the Department.

We believe that the Bureau should be continued intact, and elevated to a point where the Bureau Chief has access to the Secretary. We also favor giving the Bureau authority and appropriations to make research grants.

THE TASK FORCE RECOMMENDS

That the Children's Bureau be removed from the Social Security Administration and placed in an administrative position in the Department of Health, Education, and Welfare that will facilitate the major mission of the Bureau. This mission is to take cognizance of the needs of the whole child in the broad fields of health, education, and welfare, support necessary research in the field, and stimulate the utilization of new knowledge by the various agencies of the Federal Government within and outside the Department of Health, Education, and Welfare and in the States.

Toxemia of Pregnancy

Without question one of the most impressive and dramatic developments in American medicine within the last 50 years has been the extraordinary reduction in maternal mortality. In the year of 1924 on the obstetrical service of the Yale University Medical School there were 11 deaths in 509 cases, or a maternal mortality of 22 per thousand. A death rate this high was a frequent occurrence on teaching services at this time.

In contrast to this, there has not been a death on the University service for the past 7 years. This is also quite characteristic of the trend on both teaching and nonteaching services throughout the country during the past few years.

One only has to read through the case histories of the patients who died during those past years to realize that the three lethal fates in obstetrics were toxemia, hemorrhage and infection. The latter two have been well controlled by blood replacement techniques and antibiotics. The former has been partially controlled by both lay and professional agitation insisting on rigorous attention to prenatal care and appropriate therapy when danger signals presented themselves. Through the years it has been proven time and time again that the physician who cares for obstetrical patients should be ever watchful during the patient's prenatal course for the insidious onset with which the various types of toxemia suddenly reveal themselves. In 1953 there

were 5 maternal deaths in Connecticut attributed to toxemia of pregnancy. Here, as everywhere, to be forewarned is to be forearmed. For this purpose the Subcommittee on Toxemia of the Committee to Study Maternal Mortality of the Connecticut State Medical Society has spent considerable time in devising a technique by which these patients can be followed, and if necessary treated, so that maternal mortality can be even further reduced.

This Subcommittee, under the direction of Dr. Hugh Miller of Stamford, has spent many generous hours reviewing the toxemia cases reported from the various hospitals of this State, and, following much discussion, consultation and research, has arrived at the recommendations for the prevention and treatment of toxemia of pregnancy, as printed below. Scrupulous attention to the details of these recommendations by every physician who cares for obstetrical patients in this State, or anywhere else, should further decrease the dangers of toxemia and carry many patients through to the fulfillment of a normal pregnancy when lack of attention to these details might well result in disaster to the mother and the unborn child.

RECOMMENDATIONS FOR THE PREVENTION AND TREATMENT OF TOXEMIAS OF PREGNANCY

I. Prophylaxis.

A. How frequently should a patient be seen during the prenatal period?

1. A minimum of 1 visit every 4 weeks up to 28 weeks.
2. A minimum of 1 visit every 2 weeks from 28 to 36 weeks.
3. A minimum of 1 visit every week from 36 weeks to delivery.

B. What should be done at the time of each visit? Each visit should include as minimum:

1. The recording of blood pressure and weight.
2. The testing of urine for albumen and sugar.
3. The questioning of patient regarding symptoms of edema, headache, epigastric pain, visual disturbances.
4. Instructions as to diet. Sodium restriction (eliminating salty foods, table salt, and baking soda), high protein, high mineral, high vitamin.
5. Weight control to 2 pounds per month. Total weight gain for average patient, no more than 20 pounds.

6. Special attention and more frequent visits for patients with essential hypertension, diabetes, and previous toxemias. Consultation is desirable in such cases because of their tendency to develop toxemia.

II. Management of the office patient who shows:

A. Excessive weight gain (particularly sudden weight gain).

1. Diet, low sodium (1-2 Gm.), high protein (90-1 Gm.), mineral and vitamin. Have patient note diet for one week and submit the same. Saline cathartics and diuretics may be considered.

2. Frequent visits.

3. Hospitalization if uncontrolled.

B. Hypertension.

1. Blood pressure 140/90 or over. Particular emphasis should be placed on a rise of diastolic pressure.

2. Diet, low sodium (1-2 Gm.) and high protein.

3. Frequent visits.

4. Rest at home.

5. Sedation.

6. Report headache, edema, epigastric pain or visual disturbances at once.

7. Hospitalization if not controlled.

8. If in doubt, have consultation prior to admission.

C. Edema of face, hands, or feet.

Treatment same as for excessive weight gain.

D. Albuminuria.

Treatment same as for hypertension.

E. Hospitalization should be urged if:

1. In spite of good conservative treatment weight continues to increase excessively.

2. Elevated blood pressure continues or blood pressure continues to rise in spite of good conservative treatment as outlined.

3. Persistent edema together with unusual weight gain.

4. Albuminuria continues to be present or is increasing in amount.

F. Immediate hospitalization if there is:

1. Sudden rise in blood pressure (such as 160/-100).

2. Sudden increase in albumen.

3. Sudden increase in edema.

4. Persistent headache.

5. Epigastric pain.

6. Convulsion.

G. Patients reporting any of the following symptoms should be seen immediately:

1. Severe headache.

2. Sudden edema, particularly of the face.

3. Epigastric pain.

4. Visual disturbances.

III. Upon admission to hospital, toxemia routine should be started and there should be an immediate obstetrical consultation.

A. If patient is pre-eclamptic upon admission to hospital:

1. Treat conservatively for 24-48 hours or longer.

2. If patient is not near term and good results are being obtained from conservative treatment, ideally continue hospitalization. If patient becomes sufficiently improved, patient may be seen in doctor's office at least twice a week. Treat conservatively until baby is viable or as long as possible. If it is apparent that conservative treatment is failing, re-hospitalize patient.

3. Toxic patients must be seen frequently by nurses and doctors.

4. If patient is at or near term, consider delivery:

(a) If multipara or primigravida, induce if possible.

(b) If induction in either case seems impossible or is unsuccessful, cesarean section should be considered.

IV. Eclampsia should be treated conservatively until controlled. Then deliver by the most feasible method. Avoid cesarean if possible. Consider induction by pitocin drip and rupture of membranes.

Preoperative Predictions

There are two kinds of operations, those of necessity and those of choice. In the first-named the patient often has to take chances far beyond the risks of the operative procedure itself. A chronic nephritic or cardiac, for example, may develop a fulminating appendicitis or a gangrenous cholecystitis, or may perforate a peptic ulcer, and immediate operation may be essential. Even a minor procedure in a patient with chronic disease may be an unsuspected hazard, though less so than before the advent of modern antibiotics. Elderly men with prostatism and its various complications are frequently very poor operative risks but often require

emergency surgery. In the case of operations of choice, procedures which may be delayed until an optimum time for surgical interference, the situation is quite different. If, when first seen by the doctor, a patient presents a condition which increases the operative risks, an upper air passage infection or a poorly compensated heart lesion, for example, the procedure may safely be deferred until recovery or preliminary treatment has taken place.

Patients who have undergone operations are subject to two kinds of risks, those which are unpredictable and those whose possibility or probability can be at least suspected. Of the unpredictable complications the most common and tragic is thrombosis followed by fatal pulmonary embolism. Almost equally distressing are those cases in which a period of apnea during anesthetization leads to cerebral anoxemia and is followed by convulsions or even permanent insanity. The presence of some acute or chronic disease in a patient who needs an operation of necessity may lead to the suspicion that certain complications are likely to occur and these may be dependent not on the operation but on the type of anesthesia that is employed, for different anesthetics carry with them different hazards. Ghloroform, rarely used in this country, causes serious and even fatal liver damage in some patients. Ether irritates the respiratory tract and should be avoided when respiratory disease is present. Any anesthetic, even a spinal one, may cause sufficient temporary disturbance of respiration to result in cerebral anoxemia. Errors in technique may also lead to serious complications, such, for example, as the aspiration pneumonia which may follow operations about the nose, throat or mouth performed with the patient in such a position that, while unconscious, blood or infected saliva can drain into the lower air passages. Then there are some operations which are known to carry extra hazards: thyroid removal, for example, which may lead to acute thyrotoxicosis, and gallbladder operations, which may result in acute hepatic toxemia.

It follows from all this that certain preoperative and postoperative precautions should be carried out which have the effect of warding off or at least minimizing some of the common complications of major surgery. As a matter of fact much progress has already been made in this direction. The newer technique of getting patients out of bed at a much earlier period than was formerly considered safe

has doubtless cut down the occurrence of postoperative thrombosis and embolism. If a patient who has been operated on gives a history of previous thrombosis, anticoagulants can be given over an appropriate period and even if thrombosis occurs their use may forestal embolism. In gallbladder cases liver function tests before operation may warn the surgeon of the risks of hepatic toxemia and suitable preoperative and postoperative diet and medication may be administered. In major intestinal operations drugs which sterilize the intestinal contents are now available though not always satisfactory, and the use of free gastric and intestinal drainage is technically much further advanced than it was a generation ago. Other examples could be given of the great improvements in technique which have gradually developed and have been adopted by alert surgeons.

The internist, who is often consulted regarding the risks of operation, should be fully informed of the past history and the physical condition of the prospective surgical subject and also of the nature of the proposed operation. In many patients he may be able to make valuable suggestions as to prophylactic or postoperative treatment which may spell the difference between success and failure.

G. B.

AMA Approves Simplified Insurance Claim Form

Approval of a simplified insurance claim form drafted by a special committee of the Health Insurance Council has been granted by the AMA Council on Medical Service. The AMA Committee on Prepayment Medical and Hospital Service collaborated with the HIC committee. The form is designed for use in administering surgical expense benefits under group insurance. Physicians who practice in areas where this type of insurance coverage is prevalent will be particularly interested in this development.

Eventually the Health Insurance Council hopes to have about six insurance blanks available to accommodate the various types of benefits. Only this form (GS-1) has been approved by the AMA to date, although the council has suggested certain modifications in a second which has been approved "in principle."

Copies may be secured from the Council on Medical Service.

PROGRESS IN CLINICAL MEDICINE

A MODIFICATION OF THE HEMAGGLUTINATION TEST IN RHEUMATOID ARTHRITIS

PAUL L. BOISVERT, M.D., LELAND E. HILBURG, M.D. and GIDEON K. DEFOREST, M.D.,
New Haven

IT is well recognized that rheumatoid arthritis may present much difficulty in diagnosis and the physician must depend upon the passage of time with the development of a characteristic course for final recognition. Any test which may aid in diagnosis, especially early diagnosis, or which may lead to knowledge of the factors involved in the production of rheumatoid arthritis should have tremendous value. There is little doubt that the hemagglutination test can be a reliable diagnostic aid in rheumatoid arthritis. It may suffice to say that the test depends on agglutination by the patient's serum of sheep red cells which have been sensitized by hemolysin, the amount of hemolysin having been determined by preliminary titration. Standardization of the sensitization of sheep cells is essential to reliability and reproductibility of results. It is clear that sensitivity and specificity of the test are inversely proportional and that they are determined by the degree of sensitization. It is the attempt to adjust sensitivity and specificity that has led numerous investigators to devise variations in the basic test which would allow a maximum sensitivity without sacrificing specificity. Consequently have appeared the Rose "Differential Agglutination Titre" Test;¹ the Heller,² Ball,³ and Svartz⁴ "Absorption" Tests; the Heller "Serum Potentiation" Test;⁵ and the Svartz and Schlossmann "Absorption Rate" Test.⁶

Recently Alexander and deForest⁷ of this Clinic described their early experiences with the hemagglutination test. The results can be most easily stated at this point in terms of positive and negative tests. The test was positive in 75 per cent of 51 patients with classical rheumatoid arthritis and in one patient with scleroderma. This lone exception can best be

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Dr. deForest. *Associate Clinical Professor of Medicine, Yale University School of Medicine*

SUMMARY

The current experience of the Arthritis Clinic of the Grace-New Haven Community Hospital with the sensitized sheep cell hemagglutination test in rheumatoid arthritis is described.

The present modification of the test probably increases its reliability as a diagnostic measure. In this small series of 24 cases, 100 per cent of 19 patients with clinical rheumatoid arthritis gave positive results.

Serial hemagglutination tests indicate that the titer parallels and reflects disease activity in the "remission" type case. The hemagglutination titer does not change appreciably in examples of the "chronic" type of rheumatoid arthritis.

accepted as such. The resulting incidence of positive tests in 242 individuals, who for the most part were ill, and often with rheumatic diseases other than clear-cut rheumatoid arthritis, was less than 0.5 per cent.

These data per se would indicate that the method meets certain requirements for a diagnostic test, but actually the diagnostic value of the test as performed in 1952-53 was not established. Against the method was the fact that a positive result was indicated by an agglutination titer of 64 units or more

From the Section of Preventive Medicine and the Department of Internal Medicine, Yale University School of Medicine, and the Arthritis Clinic of the Grace-New Haven Community Hospital

Expenses of this work were defrayed in part by a grant of the United States Public Health Service, and by a grant of the Connecticut Chapter of the Arthritis and Rheumatism Foundation

while the presence of less than 64 units denoted a negative result. This is a fine dividing line since practice has shown that there is a one-tube or twofold variation in the method. The selection of a titer lower than 64 units resulted in greater sensitivity but with considerable loss in specificity. In addition, it appeared at the time that the disease had to be in an advanced state to yield a positive test. Positive tests were not observed in cases of rheumatoid arthritis of less than eighteen months duration and the incidence of positive tests in patients with probable but unproved rheumatoid arthritis was only 24 per cent. This might, but need not, suggest that severity and duration of illness determine the test results.

Support for the test was obtained from the fact that the agglutination of sensitized sheep cells by the serum of some patients with rheumatoid arthritis is striking. It appeared that this must have some significance—either diagnostic or prognostic—and

that it might be possible to alter the method in a manner to increase its real specificity.

Since the publication of the results by Alexander and deForest⁷ the test has been improved in this laboratory. This report describes the results of the modified test in a small number of selected patients from the Arthritis Clinic of the Grace-New Haven Community Hospital. These were chosen because the regularity of their visits would ensure periodic evaluation and study. Serial determinations of the hemagglutination titers were done on the sera of 19 classical cases of peripheral rheumatoid arthritis, four patients who were diagnostic problems, and one patient with psoriatic arthritis.

The technical aspects of the modified test and its general clinical use in a less selected group of cases will be described in a later paper. In brief this modification depends primarily on the use of the settled pattern of sheep red cells rather than the determination of agglutination by the usual means. The

TABLE I
RELATIONSHIP OF HEMAGGLUTINATION (SSC) TITERS TO ARTHRITIC DISEASE, ITS
DURATION AND CLINICAL TYPE

DIAGNOSIS	PATIENT	TYPE OF CLINICAL DISEASE	DURATION OF DISEASE YEARS	SSC TITER RANGE	
				HIGH	LOW
Rheumatoid arthritis	B.B.	Chronic	5	512	128
	D.D.	Chronic	4	1024	128
	I. G.	Chronic	12	1024	128
	L. G.	Chronic	5	512	256
	W. H.	Chronic	8	512	<8
	A. H.	Remission	4	512	16
	E. H.	Chronic	2	512	128
	L. H.	Chronic	16	512	128
	H. L.	Chronic	5	1024	256
	E. M.	Remission	7	64	<8
	E. M.	Chronic	13	512	<8
	R. P.	Remission	2	256	16
	C. P.	Remission	29	256	<8
	H. R.	Remission	3	512	<8
	B. R.	Remission	4	256	<8
	M. S.	Chronic	7	512	128
	M. S.	Chronic	7	1024	64
	A. U.	Chronic	23	64	<8
	S. W.	Remission	8	64	<8
Osteoarthritis ? Rheum. arth.	T. B.	Remission	5	<8	<8
	E. L.	Remission	12	<8	<8
Gouty arthritis ? Rheum. arth.	H. G.	Chronic	5	<8	<8
Pager's Disease Osteoarthritis	R. G.	Chronic	32	<8	<8
Psoriatic arth.	A. D.	Chronic	4	<8	<8

technique enables one to use less hemolysin, thereby avoiding many of the equivocal results. Furthermore, the serum titer from patients with rheumatoid arthritis is not lowered and both normal and non-rheumatoid individuals fail to react.

Table 1 summarizes the range of hemagglutination titers in the various groups of patients. According to the new modification a titer of eight and over is considered positive. "Type of clinical disease" refers to the overall clinical picture of the patient from a consideration of all the indices of clinical status. It can be divided into two types. One type is termed "chronic" and can best be described as a smoldering case of rheumatoid arthritis. The patient may improve on therapy but does not show dramatic reversal of the disease process and is never really free of arthralgia and stiffness. Clinically, progression of the disease to actual joint deformity occurs more often than not. The "remission" type represents patients whose disease activity changes strikingly to a clinically inactive form. From a comparison of these two "type" patients certain generalizations can be made. "Chronic" type patients usually maintain high titers. Their lowest titers seldom fell below 1:128 units. "Remission" type patients always had some titers below 1:128, and most often their lowest titers were less than eight. Furthermore, the drop in titer paralleled clinical improvement. This is well illustrated by patients A. H., C. P., H. R., B. R., and S. W. The other two cases of this "remission" type, E. M. and R. P., have recently had exacerbations of their disease at which time their hemagglutination titers increased. Thus it appears that a difference in titer antedates or accompanies clinical changes in such patients, while "chronic" cases usually show no significant variations in titer. This would imply that these patients are never really inactive. Clinical evidence supports this.

There seems to be no correlation between duration of symptoms and the type of serial response that the patient will show in the hemagglutination test. One "chronic" patient, A. U., consistently had low serum titers. A most likely explanation is that the long duration of her disease, 23 years, was responsible. Such a patient is classified as a "burnt-out" example of rheumatoid arthritis. Alexander and deForest⁷ in 1952 reported that sera from very long standing cases of rheumatoid arthritis generally showed lower titer levels.

It is interesting that T. B. and E. L., patients with a questionable diagnosis of rheumatoid arthritis,

never had serial titers higher than less than eight. Extensive current experience with the test indicates that positive reactions are observed almost exclusively in rheumatoid arthritis. On this evidence positive tests might have established the diagnosis of rheumatoid arthritis in these two cases. However, consistently negative tests suggest, but do not prove, the absence of this disease, since even with the present improvements in method it is unlikely that 100 per cent of patients with rheumatoid arthritis would react.

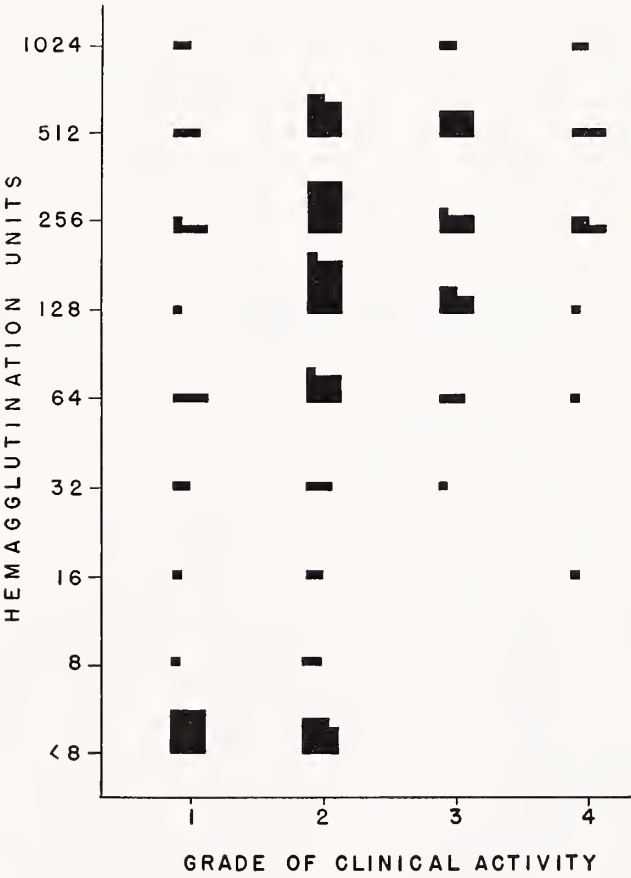


FIGURE 1
Relationship of hemagglutination titer to activity in rheumatoid arthritis

Figure 1 plots grade of activity as outlined by Steinbrocker *et al.*⁸ against 193 hemagglutination test results. A titer of 1:64 (64 units) or higher can usually be taken as a sign of disease activity, whereas a lower titer indicates minimal activity or inactivity by this classification.

Figure 2 compares the results of 148 concomitant ESR (erythrocyte sedimentation rate) and hemagglutination titer determinations. There appears to be a rough correlation between the two. Certainly a hemagglutination titer of 1:64 or higher most often

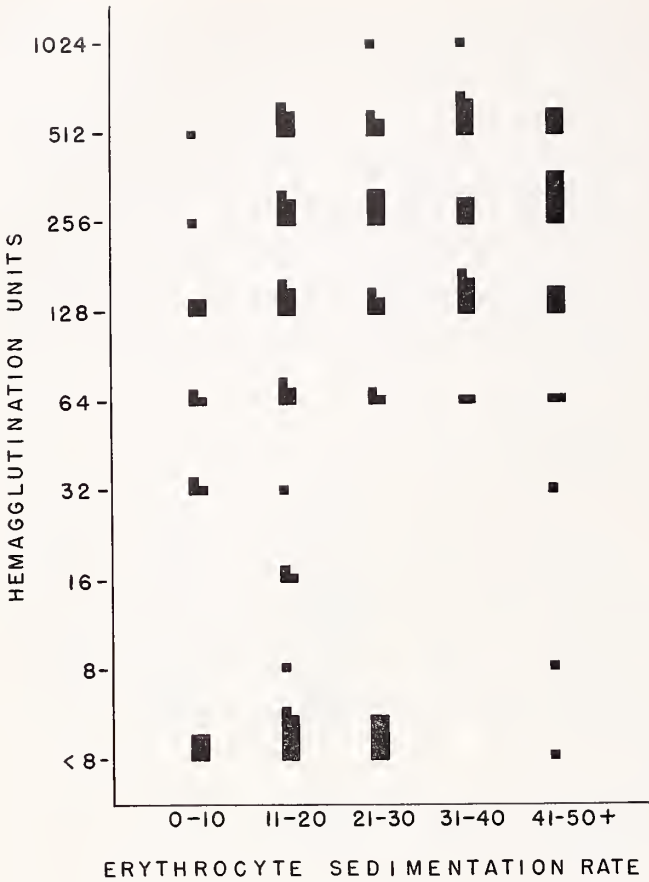


FIGURE 2
Relationship of hemagglutination titer to erythrocyte sedimentation rate in rheumatoid arthritis

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New Booklet On Federal Income Tax Liability

The AMA Law Department has compiled a booklet on the federal income tax liability of physicians, consisting of a reprinting of four articles which appeared recently in *The Journal*. This booklet is available to state and county medical societies and individual physicians, without charge, by writing the Law Department, American Medical Association.

accompanies an elevated ESR. An ESR greater than 30, which usually indicates activity, is accompanied by a hemagglutination titer of 1:32 or higher. These findings agree with those of Winblad⁹ in 1951 and¹⁰ 1952. Others, though, have found no such correlation.^{1,11,12,13,14}

A continuous study of the test in all possible varieties of rheumatoid arthritis substantially supports these impressions. It is impossible at this time to define in exact terms the general value of the hemagglutination test. It is clear from recent findings not herein recorded that positive and even strongly positive tests can be obtained within three months from onset of symptoms.

The authors are indebted to Dr. John R. Paul for his helpful criticism and advice.

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Council Meeting

A special meeting of the Council was held at the offices of the Society on March 17, 1955. The meeting was called to order by the chairman at 4:00 P. M. There were present in addition to the Chairman Dr. Danaher, Drs. Marvin, Couch, Barker, Weld, Gibson, Feeney, Ursone, Russell, Labensky, Ottenheimer, Clarke, Buckley, Dwyer. Absent: Drs. Stringfield, Murdock, Gildersleeve, Fincke, Gallivan, Tracy, Flaherty, Gens, Walker, Archambault, Gilman.

The primary purpose for this meeting was to consider the report of the special committee that had been appointed to review the legislative commission report on the establishment of a medical school in the University of Connecticut. A few other items were taken up prior to that consideration.

A copy of the nomination and curriculum vitae of John Rodman Paul, submitted to the American Medical Association in support of Dr. Paul's nomination to receive the Distinguished Service Award, was presented for information (see item No. 10 Council Minutes, February 17, 1955).

The Report of the Special Committee on the State Medical School (AMB 2/17/55—"B") was next considered and Dr. Louis P. Hastings who had served as Chairman of the committee joined the Council. Many questions were asked of Dr. Hastings and the subject was thoroughly discussed. In addition to the Report of the Hastings Committee, a letter from Dr. James M. Faulkner, dean of the Boston University School of Medicine, written to Mr. Robert H. Alcorn, chairman of the Medical School Commission, was also presented.

It was first voted to accepted with appreciation the report of the special committee. Later it was voted to approve the report and its recommenda-

tions with certain minor changes in wording and the legislative committee of the Society and the executive secretary are to support the bills SB40, SB47, and HB113, now pending before the Connecticut General Assembly which are to be held by the Committee on Education on March 23, 1955.

It was voted to appoint Jessie E. Parkinson, Hartford, to be a member of the Committee to Study Maternal Mortality and Morbidity, and Dr. Parkinson is also to be nominated to the committee for 1955-56.

The executive secretary reported the sudden death of Alfred J. Sette, Stamford, an active and valued member of the Committee on Public Relations. In conversation with Dr. Fincke, the Councilor from Fairfield County, the executive secretary learned that the Board of Directors of Fairfield County Medical Association was to meet on the evening of March 17 and that another member of the association would be selected to fill the vacancy left by the death of Dr. Sette. It was agreed that whoever was suggested by the Board of the Fairfield County Medical Association would be appointed to the committee without further action by the Council.

The Report submitted by the Hospital Committee was presented for discussion, (AMB 3/17/55—"A") and Ralph T. Ogden, chairman of the Committee, joined the Council at this time. There was lengthy discussion of the report and it was finally voted that it be included in the Agenda of the House of Delegates meeting on April 26, 1955 without comment from the Council.

The Report submitted by the Special Committee to Study Third Party Payments for Medical and Ancillary Non-Surgical Services (AMB 3/17/55—"B") was scheduled for discussion, but because of the lateness of the hour it was not taken up.

New Members

FAIRFIELD COUNTY

Peter A. Arturi, Greenwich
 Norman F. Boas, Wilton
 Erval R. Coffey, Greenwich
 Arthur W. Freidinger, Westport
 James F. Gammill, Darien
 John H. Heller, Ridgefield
 Joseph L. Horowitz, Bridgeport
 Patrick A. Izzo, Stamford
 Louis Keller, Stamford
 James V. MacGregor, Darien
 William R. Maniatis, Bridgeport
 Laura G. Morgan, Stamford
 Edward P. Perley, Norwalk
 Richmond Stephens, Stamford
 Lockwood Towne, Newtown
 Leslie A. Tury, Bridgeport
 James F. Walsh, III, Bridgeport
 John C. Wilsey, Greenwich
 Michael Yoburn, Danbury

HARTFORD COUNTY

Joseph T. Arcano, Southington
 G. Lawrence Austin, Jr., Hartford
 Robert T. Barry, Hartford
 Ronald W. Cooke, West Hartford
 Sidney J. Curran, New Britain
 Robert C. Doherty, Hartford
 Otto G. Goldkamp, Hartford
 Joseph W. Gramer, Wapping
 Maxwell E. Hagedorn, New Britain
 John H. Hage, Hartford
 Neil D. Josephson, New Britain
 Bernard J. Kaplan, West Hartford
 Arthur D. Keefe, West Hartford
 Thomas K. Lammert, Hartford
 Peter C. Loewenberg, East Hartford
 Daniel A. LoPresti, Hartford
 Richard H. Maloney, Jr., Hartford
 Gregory T. O'Connor, Hartford
 Charles P. Powell, Rocky Hill
 Ernest C. Shortliffe, Hartford
 Colby S. Stearns, Hartford
 Otto C. Steinmayer, Jr., Bristol
 Gregory S. Slater, New Britain
 Earle E. VanDerwerker, Jr., Hartford
 Kenneth E. Ward, Hartford
 Arne Welhaven, Hartford

NEW HAVEN COUNTY

Henry H. Altenberg, Meriden
 Lane Ameen, West Haven
 Albert W. Barile, New Haven
 Charles O. Bechtol, New Haven
 John M. Bellis, Jr., New Haven
 William B. A. Bentley, Waterbury
 William C. Billings, New Haven
 Marvin L. Cousins, New Haven
 Joseph C. Elia, Milford
 David D. Giardina, New Haven
 Irving Glassman, New Haven
 Herbert Goldenring, Branford
 William E. Hill, Jr., Naugatuck
 Geraldine R. Huss, Derby
 Carl A. Jaeger, New Haven
 Joseph M. James, Waterbury
 Kenneth G. Johnson, New Haven
 Kenneth R. Kaess, Waterbury
 Joseph L. Kaplowe, New Haven
 Jay Katz, New Haven
 William B. Kinlaw, West Haven
 Charles R. Kleeman, New Haven
 Bernard Klein, South Meriden
 Sidney Licht, New Haven
 Waldo E. Martin, Milford
 John C. Mendillo, New Haven
 John C. Moench, Wallingford
 Paul E. Molumphy, New Haven
 Walter S. Morgan, Hamden
 John J. O'Neill, New Haven
 William A. O'Shea, Jr., New Haven
 Richard D. Otis, New Haven
 Howard M. Spiro, New Haven
 John E. Standard, Naugatuck
 Harriet T. Sullivan, New Haven
 Lawrence M. Tierney, West Haven

NEW LONDON COUNTY

Walter M. Brown, Groton
 Harvey Mandell, Norwich
 Clemens E. Prokesch, New London
 Elsie M. Tytla, New London
 Franklyn P. Ward, Norwich

Meetings Held During April

April 4—Fairfield County Medical Association
 April 5—Hartford County Medical Association
 Committee on Public Relations

- April 6—Committee on State Legislation
 Joint Meeting—Committee to Study
 Maternal Mortality and Morbidity and
 Subcommittee on Toxemia
 Conference with Representatives of Oph-
 thalmology
- April 7—Executive Committee Board of Directors
 of CMS
 Conference with Connecticut Hospital
 Association re: Prepaid Medical Insur-
 ance
 Administrative Committee to Bureau of
 Rehabilitation
 New London County Medical Association
- April 11—Committee on State Blood Bank
 Conference on State Hospitalization
- April 12—Committee on Psychiatric Services in
 General Hospitals
- April 13—Committee on Neonatal Mortality
- April 14—Committee on Public Health
 Committee on Postgraduate Education
 Middlesex County Medical Association
- April 19—Litchfield County Medical Association
 Tolland County Medical Association
- April 20—Local Committee on Arrangements for
 State Meeting
- April 21—Subcommittee on School Health
 Windham County Medical Association
- April 26, 27, 28—163rd Annual Meeting of the State
 Medical Society

Officers and Committees to be Elected by the House of Delegates

President-Elect	Ralph T. Ogden, Hartford
First Vice-President	John D. Booth, Danbury
Second Vice-President	John F. Kilgus, Litchfield
Treasurer	Frank H. Couch, Cromwell
Executive Secretary	Creighton Barker, New Haven
Managing Editor of JOURNAL	Stanley B. Weld, Hartford
Literary Editor of JOURNAL	H. M. Marvin, New Haven

ONE DELEGATE AND ONE ALTERNATE TO THE AMERICAN
 MEDICAL ASSOCIATION—for the term January 1, 1956
 to December 31, 1957

Thomas J. Danaher, Torrington
 Alternate—Oliver L. Stringfield, Stamford

AMA COUNCILOR

Thomas P. Murdock, Meriden

COUNCILOR-AT-LARGE

H. M. Marvin, New Haven

SPEAKER OF THE HOUSE OF DELEGATES

Cole B. Gibson, Meriden

VICE-SPEAKER

Thomas M. Feeney, Hartford

COMMITTEE OF POST-GRADUATE EDUCATION—to appoint the
 entire committee and name chairman. (Not less than
 seven members.)

Arthur Ebbert, New Haven, *Chairman*

Gray Carter, Greenwich

Malcolm M. Ellison, New London

Martin E. Gordon, New Haven

William J. Lahey, Hartford

John C. Leonard, Hartford

Howard Levine, New Britain

Marvin Lillian, Woodbridge

Robert M. Lowman, New Haven

A. Rocke Robertson, Torrington

Charles Russman, Middletown

EDITORIAL BOARD OF THE JOURNAL—to nominate entire com-
 mittee, not more than fifteen members

H. M. Marvin, New Haven, *Chairman*

Frederick A. Beardsley, Willimantic

Hugh J. Caven, Hartford

Mark A. Hayes, New Haven

Samuel D. Kushlan, New Haven

Thomas Mackie, Westport

Ward McFarland, New London

Marshall Pease, Ridgefield

Charles H. Peckham, Manchester

Clair Rankin, Hartford

Allan J. Ryan, Meriden

Michael S. Shea, New Haven

Mark Thumin, Middletown

Stanley B. Weld, Hartford

COMMITTEE ON HONORARY MEMBERS AND DEGREES—shall
 consist of three latest past presidents, one member
 for a term of three years to succeed Brae Rafferty

Edward J. Whalen, Hartford, *Chairman*

George H. Gildersleeve, Norwich

H. M. Marvin, New Haven

COMMITTEE ON HOSPITALS—to nominate entire committee,
 not less than six members, and appoint chairman

George H. Gildersleeve, Norwich, *Chairman*

Arthur J. Adams, Torrington

M. David Deren, Bridgeport

Frederick B. Hartman, New London

Kenneth K. Kinney, Willimantic

Michael S. Shea, New Haven

Charles T. Schechtman, New Britain

Alfred B. Sundquist, Manchester

Hiram Sibley, New Haven, Associate Member

COMMITTEE ON INDUSTRIAL HEALTH—to nominate the entire committee, not less than ten members, and appoint chairman

John F. Kilgus, Litchfield, *Chairman*
 Preston N. Barton, Meriden
 Harold A. Bergendahl, Norwich
 Norton Canfield, New Haven
 Roland Z. Carignan, West Hartford
 George H. Carter, Willimantic
 Bernard S. Dignam, Thompsonville
 Richard J. Hinchey, Waterbury
 Andrew J. Jackson, Waterbury
 J. Howard Johnston, Hartford
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 Daniel F. Levy, New Haven
 J. Wister Meigs, New Haven
 Philip J. Moorad, New Britain
 Frank T. Oberg, Bridgeport
 John D. O'Connell, Hartford
 Israel S. Otis, Meriden
 Norman Righthand, Stamford
 Philip E. Schwartz, Middletown
 Harold P. Stetson, Southington
 Paul W. Vestal, New Haven
 Ellwood C. Weise, Bridgeport
 Harold W. Wellington, New London
 J. Alfred Wilson, Meriden
 C. Frederick Yeager, Bridgeport

COMMITTEE ON MEDICAL EDUCATION AND LICENSURE—a nomination to the Conn. Medical Examining Board, one member for a period of five years to succeed Carl E. Johnson, commencing January 1, 1956

Carl E. Johnson, New Haven
 C. Louis Fincke, Stamford (1957)
 Louis P. Hastings, Hartford (1958)
 John H. Bumstead, New Haven (1959)
 John D. Booth, Danbury (1960)

PROGRAM COMMITTEE—one member for a term of three years to succeed Samuel D. Kushlan
 Walter Weissenborn, Hartford, *Chairman*
 James W. Major, Willimantic
 Vernon W. Lippard, New Haven

COMMITTEE ON PUBLIC HEALTH—to nominate the entire committee and appoint chairman. This committee is limited to 15 and must have a representative from each county

Robert R. Keeney, Jr., Manchester, *Chairman*
 David H. Bates, Putnam
 John W. Buckley, Bridgeport
 Alfred L. Burgdorf, Hartford
 Francis H. Burke, Rockville
 Clarence W. Harwood, Middletown
 Louis P. Hastings, Hartford
 Andrew W. Orlowski, Torrington
 Leonard Parente, Hamden
 Robert P. Rogers, Greenwich
 J. Harold Root, Waterbury
 Arthur A. Tower, Meriden

William A. Wilson, Hartford
 Joseph M. Wool, New London

COMMITTEE ON STATE LEGISLATION—appoint chairman. Members nominated by the county associations

Fairfield—John G. Murray, Greenwich
 Hartford—Alfred L. Burgdorf, Hartford *Chairman*
 Litchfield—Winfield E. Wight, Thomaston
 Middlesex—Asher L. Baker, Portland
 New Haven—Samuel B. Rentsch, Derby
 New London—Edmund L. Douglas, Groton
 Tolland—Vacancy
 Windham—Karl T. Phillips, Putnam

COMMITTEE ON PUBLIC RELATIONS—to nominate entire committee, to consist of eight members, and appoint chairman

William G. H. Dobbs, Torrington, *Chairman*
 Harold A. Bergendahl, Norwich
 James C. Canniff, Torrington
 Morris A. Hankin, New Haven
 Harry C. Knight, Middletown
 D. Olan Meeker, Riverside
 James H. Root, Jr., Waterbury
 Stewart P. Seigle, Hartford
 William A. Richardson, Noroton, Associate Member

CANCER COORDINATING COMMITTEE—to nominate entire committee and appoint chairman. This committee shall be not less than seven nor more than nine members and at all times include the President of the Connecticut Cancer Society, President of the Association of Tumor Clinics, and a representative of the State Health Department

Allan J. Ryan, Meriden, *Chairman*
 Matthew H. Griswold, Hartford
 Mark A. Hayes, New Haven
 William Mendelsohn, New Haven
 Benjamin R. Reiter, Bridgeport
 Robert Tennant, West Hartford
 Vincent J. Vinci, Middletown
 President, Connecticut Cancer Society
 President, Association Tumor Clinics

COMMITTEE ON MENTAL HEALTH—to nominate entire committee, not more than eight members, and appoint chairman

Clifford D. Moore, Stamford, *Chairman*
 Francis J. Braceland, Hartford
 John H. Bumstead, New Haven
 Charles W. Culotta, New Haven
 Franklin S. DuBois, New Canaan
 John H. Foster, Waterbury
 Foster E. Priddy, Hartford
 G. Gardiner Russell, Hartford

COMMITTEE ON THIRD PARTY PAYMENTS—to nominate entire committee, not more than five members, and appoint chairman

William H. Curley, Jr., Bridgeport, *Chairman*
 Donald G. Arnault, Middletown
 Russell A. Keddy, Stamford
 Henry Merriman, Waterbury
 Benjamin V. White, Hartford

DELEGATES TO STATE SOCIETIES AND SPECIAL SOCIETIES—for a term of one year July 1, 1955 to June 30, 1956

To Maine:

Norman H. Gardner, East Hampton
Stanley B. Weld, Hartford

To Massachusetts:

Ralph L. Gilman, Storrs
John C. Leonard, Hartford

To New Hampshire:

Eric H. Blank, New London
Clyde L. Deming, New Haven

To New Jersey:

E. Tremain Bradley, New Canaan
John H. Bumstead, New Haven

To New York:

H. M. Marvin, New Haven
Oliver L. Stringfield, Stamford

To Rhode Island:

Gerard M. Chartier, Danielson
William J. H. Fischer, Milford

To Vermont:

Courtney C. Bishop, New Haven
Charles T. Schechtman, New Britain

To Connecticut Hospital Association

Chairman of Hospital Committee

To Connecticut Pharmaceutical Association

Barnett Greenhouse, New Haven

To Connecticut State Dental Association:

The President

To Connecticut Nurses' Association

The President-Elect

Committees Appointed by the Council Without Election by the House of Delegates

Excerpts from minutes of the Nominating Committee meeting December 21, 1949.

"It was agreed that the amendment to the by-laws creating the Nominating Committee was to be construed that the Nominating Committee would not only nominate officers and committees to be elected by the House of Delegates but would also nominate to the Council, members to serve on committees that are appointed by the Council without election by the House of Delegates."

COMMITTEE ON COOPERATION WITH THE YALE SCHOOL OF MEDICINE

Maxwell Lear, New Haven, *Chairman*
Howard S. Colwell, New Haven
Daniel Hardenbergh, Bridgeport
Edward Nichols, Hartford
Allan M. Ross, Darien
N. William Wawro, Hartford

CONFERENCE COMMITTEE WITH CONNECTICUT PHARMACEUTICAL ASSOCIATION

Barnett Greenhouse, New Haven, *Chairman*
Martin I. Hall, Bristol
Benjamin Katzin, Torrington
Walter J. Keefe, Hartford
William V. Wener, Norwich

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Morton Arnold, Willimantic
Orvan W. Hess, New Haven
Winfield O. Kelley, Norwich
Steven P. Magyar, New Haven
Frank L. Polito, Torrington
Alfred B. Sundquist, Manchester
Jacques Van B. Voris, Darien

COMMITTEE ON NATIONAL LEGISLATION

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Joseph A. Fiorito, New Haven
Henry Merriman, Waterbury
Karl T. Phillips, Putnam
Charles T. Schechtman, New Britain
Edward P. White, Hartford
Chairman, Committee on State Legislation
Executive Secretary

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Lane Giddings, Manchester
Frederick B. Hartman, New London
Christie E. McLeod, Middletown
Sawyer E. Medbury, Willimantic
Lincoln Oppen, Torrington
Edward V. Stevenson, Pomfret
John E. Thayer, Hartford
Victor G. H. Wallace, Hartford
Levin Waters, New Haven
Ira V. Hiscock, New Haven, Associate Member

COMMITTEE ON MEDICAL CARE OF VETERANS

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James S. Missett, Hartford
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William H. Upson, Suffield

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Within one year of the day it was offered to the medical profession, ACHROMYCIN had proved effective against a wide variety of infections caused by Gram-negative and Gram-positive bacteria, rickettsiae, and certain viruses and protozoa.

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William H. Upson, Suffield
Harold D. VonGlahn, Old Lyme

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Representative from Connecticut State Nurses'
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Representative from Connecticut Hospital
Association
Representative from Connecticut State Dental
Association
Representative from Connecticut Pharmaceutical
Association

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D. Dillon Reidy, Hartford
J. Forbes Rogers, Stamford
Representatives from Connecticut State Nurses'
Association
Representatives from Connecticut Hospital Association
Representative from League of Nursing—Public Health
Association

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Cornelius S. Conklin, Bridgeport
Camille H. Huvelle, Torrington
Brae Rafferty, Willimantic

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Stanley B. Weld, Hartford
President, Connecticut State Medical Society

REPRESENTATIVES OF CONNECTICUT HEALTH LEAGUE

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Clement F. Batelli, New Haven
Frederick L. Nichols, Hartford

COMMITTEE TO STUDY NEONATAL MORTALITY

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 Clarence W. Harwood, Middletown
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 Charles A. Murphy, Stamford
 Charles H. Peckham, Manchester

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 Egbert M. Andrews, Hartford
 Norton Canfield, New Haven
 Samuel B. Rentsch, Derby
 Stanley B. Weld, Hartford

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 Andrew J. Jackson, Waterbury
 H. M. Marvin, New Haven
 Nicholas E. St. John, Hartford

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EDUCATION FOUNDATION (AMEF)

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 Fairfield—Milton M. Lieberthal, Bridgeport
 Hartford—Charles E. Jacobson, Jr., Hartford
 Litchfield—G. Robert Downie, Winsted
 Middlesex—Louis O. LaBella, Middletown
 New Haven—Orvan W. Hess, New Haven
 New London—Paul J. Gerity, New London
 Tolland—Marjorie A. Purnell, Rockville
 Windham—Mervyn H. Little, Willimantic

Dr. Horton Renamed to Blue Shield Commission

Dr. William H. Horton of Windsor was renamed to membership on the Blue Shield Commission for his third successive term following elections during the annual conference of Blue Shield Medical Care plans at the Edgewater Beach Hotel, Chicago. Dr. Horton is executive director of Connecticut Medical Service, the statewide surgical-medical care plan sponsored by The Connecticut State Medical Society.

Dr. Norman Welch of Boston and Dr. Horton will serve as Commissioners from the First Blue Shield District, which includes all of the New England States and the Maritime Provinces of Canada.

In addition to his work as a commissioner, Dr. Horton was reappointed to the Technical Assistance Board which acts in an advisory capacity to assure the sound operation of the medically sponsored Blue Shield plans.

Yale Acquires Old Manuscript

One of the world's most famous medical manuscripts—the 600-year-old Codex Paneth—has been acquired by the Yale Medical Library.

This rare, early medieval work containing 1,378 pages, all of them in excellent condition, is believed to have been the entire medical library of the University of Prague when it was founded in 1347-48.

The beautifully colored illuminations, hand drawn by painstaking craftsmen, give an insight not only to the art of the early 14th Century but also to the amazingly advanced surgical instruments of the time. Many of the scalpels, surgical saws, forceps and orthopedic instruments shown in this manuscript look remarkably modern.

In fact, some of the instruments shown in these manuscripts are still being used in slightly modified form, according to Frederick G. Kilgour, librarian of the Yale School of Medicine.

For more than 70 years the Codex, regarded as one of the most important medieval medical manuscripts still extant, was owned by the Paneth family of Germany. Friedrich A. Paneth, the most recent owner, was a professor of physics at the University of Durham in England and is now director of the Max Planck Institute in Heidelberg.

Before being acquired by the Paneth family, it was in the Cathedral Library of Olmutz, and at one time is believed to have been at Mylau in Saxony.

The manuscript consists of 42 separate texts which represent a cross section of all medical knowledge available up to the beginning of the 14th Century. A note on the final page of the manuscript indicates that it was completed June 5, 1326.

\$144,163 to Connecticut for Cancer Research

The American Cancer Society is allotting a total of \$144,163 for cancer projects at Yale, University of Connecticut, and Wesleyan this year. Of this, \$133,000 goes to Yale which already has a \$50,000 patient-research project underway.

THE HISTORIAN'S NOTE BOOK

SCARLET FEVER FROM 1675 TO 1954

A. S. BRACKETT, M.D., *Riverside*

THE first published differentiation of scarlet fever from measles was by Sydenham in 1675. When Sydenham first distinguished scarlet fever, he considered measles the more serious; but later malignant epidemics of scarlet fever changed his mind.

An epidemic of mild scarlet fever occurred in Boston in 1735 according to Ernest Caulfield, M.D.* John Huxham in England, in 1757, described cases which he called "malignant ulcerous sore throat" which had a red rash and a disquamation of the hands. Such cases occurred for more than a century until the discovery of toxin antitoxin offered effective control of diphtheria. It seems probable that such cases were scarlet fever complicated with diphtheria.

Dewees in his "Treatise on the Physical and Medical Treatment of Children" published in 1825 devoted six pages (Chapter 34) to "scarletina" or

scarlet fever. (This follows a chapter of eighteen pages devoted to "worms").

"Eberle on Children," Chapter 37, page 85, says that "The prevailing epidemic may be mild or severe."

In 1848, Toomey in Brenemann's Practice of Pediatrics (Vol. II, Chapter 23, page 21) says, "One must not lose sight of the fact that the type of scarlet fever seen in the past several years has been very mild in character and the complications have been neither very numerous nor severe, even in the untreated cases." And on page 17, "Of those who died 20 per cent were found to have virulent diphtheria in the throat."

In my own active practice extending from 1896 to 1950 I cannot remember a single severe case of scarlet fever. Wondering about this, I wrote to the Connecticut State Board of Health. They referred my enquiry to Mr. Clapis of the Bureau of Vital Statistics, who sent me the following data:

*The Throat Distemper of 1735-1740, *Yale Journal of Biology and Medicine*, 1939. New Haven, Connecticut.

CASES				DEATHS			
YEAR	NUMBER	RATE PER	5 YR. CASE	NUMBER	RATE PER	5 YR. DEATH	5 YR. FATALITY
		100,000			100,000	5 YR. DEATH	
		POP.	RATE AVG.		POP.	RATE AVG.	RATE AVG.
							(PER 100 CASES)
1895	1359	164.5		65	7.9		
1896	1309	155.2		82	9.7		
1897	1675	195.1		69	8.0		
1898	1126	128.7		38	4.3		
1899	1521	170.5		50	5.6		
1895-99			162.7			7.1	4.3
1900	1781	196.1		68	7.5		
1901	1960	210.9		84	9.0		
1902	2551	268.5		169	17.8		
1903	2474	254.9		148	15.2		
1904	1781	179.7		83	8.4		
1900-04			222.0			11.6	5.2
1905	1550	153.2		51	5.0		
1906	1450	140.4		57	5.5		
1907	1476	140.1		67	6.4		
1908	1564	145.7		60	5.6		
1909	2219	202.8		117	10.7		
1905-09			156.9			6.6	4.3

YEAR	CASES			DEATHS			5 YR. FATALITY RATE AVG. (PER 100 CASES)
	NUMBER	RATE PER	5 YR. CASE RATE AVG.	NUMBER	RATE PER	5 YR. DEATH RATE AVG.	
		100,000 POP.			100,000 POP.		
1910	3112	278.3	206.7	127	11.4	8.8	4.2
1911	2720	237.4		103	9.0		
1912	1821	155.2		88	7.5		
1913	2499	208.2		114	9.5		
1914	1969	160.4		81	6.6		
1910-14							
1915	1641	130.7	130.8	33	2.6	2.5	1.9
1916	1181	92.1		30	2.3		
1917	1528	116.7		21	1.6		
1918	1550	115.9		36	2.7		
1919	2663	195.1		45	3.3		
1915-19							
1920	4028	289.4	281.2	74	5.3	4.9	1.7
1921	4001	283.0		102	7.2		
1922	3132	218.1		62	4.3		
1923	3372	231.3		53	3.6		
1924	5658	382.3		58	3.9		
1920-24							
1925	4005	266.6	197.8	45	3.0	1.8	0.9
1926	3064	201.0		35	2.3		
1927	3319	214.7		22	1.4		
1928	2730	174.1		22	1.4		
1929	2174	136.7		15	0.9		
1925-29							
1930	3082	191.5	175.2	25	1.6	1.1	0.6
1931	1968	121.5		12	0.7		
1932	3438	210.9		19	1.2		
1933	3766	229.6		22	1.3		
1934	2025	122.7		13	0.8		
1930-34							
1935	2761	166.3	173.0	24	1.4	0.7	0.4
1936	2269	135.8		12	0.7		
1937	3870	230.2		11	0.7		
1938	3129	185.0		4	0.2		
1939	2517	147.9		4	0.2		
1935-39							
1940	2540	148.4	121.8	0	0.0	0.1	0.05
1941	1759	99.9		2	0.1		
1942	1350	74.0		0	0.0		
1943	2729	146.0		2	0.1		
1944	2657	140.3		1	0.1		
1940-44							
1945	2144	112.6	74.1	2	0.1	0.1	0.1
1946	1579	82.4		2	0.1		
1947	1276	66.1		0	0.0		
1948	1094	56.2		0	0.0		
1949	1078	54.4		1	0.1		
1945-49							
1950	847	42.0		0	0.0		
1951	784	38.3		0	0.0		
1952	1870	89.2		0	0.0		
1953	3054	141.7		1	0.05		

It is interesting to note that, whereas the death rate from scarlet fever averaged more than 322 per 100,000 of population in the ten years from 1875 to 1885, in the last nine years reported, from 1945 to 1953, the death rate did not rise above 0.1 per 100,000 and in four of those years there were no deaths.

One might think that this improvement was due wholly to the use of sulpha drugs and antibiotics; but when we remember that the sulpha drugs were

None of these, however, nor all of them, are sufficient to explain the improvement. It seems rather to be an unknown factor such as we encounter so often in dealing with disease.

Connecticut Committee on Foods, Drugs,
Cosmetics and Devices
Meeting of January 27, 1955

The member societies and institutions were represented at this meeting as follows: Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut Pharmaceutical Association, Prof. Nicholas W. Fenney; Connecticut State Dental Association, Dr. William Kirschner; Connecticut State Medical Society, Dr. Hugh Dwyer; Connecticut Veterinary Medical Association, Dr. Joseph DeVita; University of Connecticut, Dr. Stanley E. Wedberg; University of Connecticut College of Pharmacy, Dean Harold Hewitt; Yale University School of Medicine, Dr. Desmond D. Bonnycastle.

The following were also present: Dr. Felix Blanc, representing the Pharmacy Commission; Dr. James C. Hart, representing the State Department of Health; Mr. Herbert Plank, representing the Food and Drug Commission.

“DIAMOND SPARKLING HEALTH WATER”

At the December 2 meeting Mr. Plank had turned over to Dr. Fisher for analysis a bottle of club soda of the above name made by Diamond Ginger Ale Inc., Waterbury, Connecticut, which was labelled “Salt Free, Scientifically Treated and Carbonated.” Dr. Fisher reported that analysis by his laboratory had shown the following sodium and chloride contents, as compared with New Haven city water:

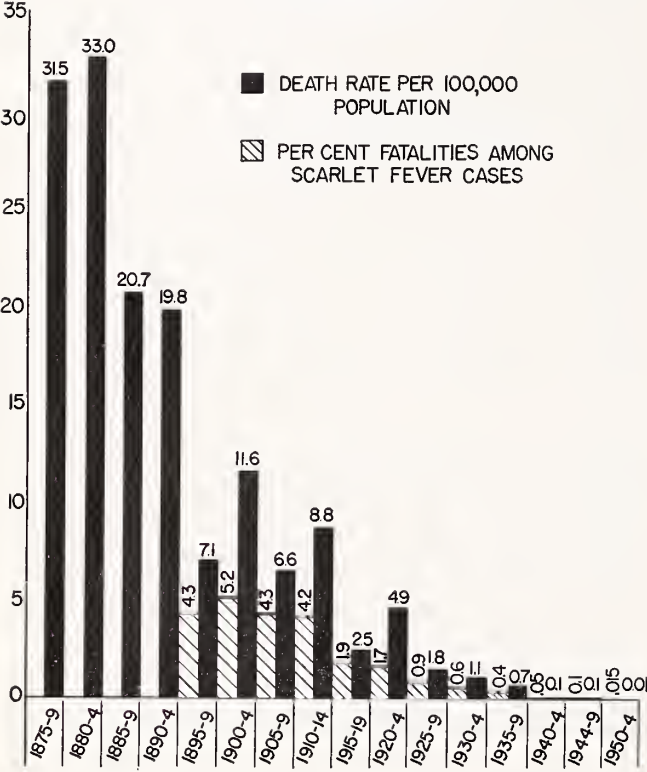
	“DIAMOND SPARKLING HEALTH WATER”	NEW HAVEN CITY WATER
Sodium, p.p.m.	4.9	4.8
Chloride, p.p.m.	14.6	6.3

That is, the sodium content of Diamond Sparkling Health Water was essentially identical with that of tap water and its chloride content was over twice as great; there was no evidence that the “scientific treatment” had removed any salt.

Dr. Dwyer remarked that he thought 4.9 p.p.m. of sodium was little enough for the product to be considered “salt-free” from a therapeutic standpoint, and he considered the “scientifically treated” claim to be only trade puffery. Dr. DeVita and Mr. Plank both replied that they believed the economic aspect of the deception should be considered.

No action was taken by the Committee.

DEATH RATE AND FATALITY RATE FROM SCARLET FEVER
IN CONNECTICUT



not used medically until 1932, we see that this was almost at the bottom of the decline in the death rate. We would expect also that this might have been due to more effective measures to control the incidence of infection; but again a plotting of this data shows that not only is the death rate down (the number of deaths due to scarlet fever per hundred thousand of the population) but the fatality rate has dropped consistently (the percentage of deaths among the reported cases). In the nine years 1945-53 the average fatality rate was less than 0.02 per cent.

One might speculate that the general use of toxin antitoxin and resulting immunity to diphtheria was an important factor, at least in the twenty per cent of deaths referred to by Toomey.

BILLS REQUIRING THE NAMES OF HAZARDOUS INGREDIENTS AND ANTIDOTES THEREFOR TO BE CARRIED ON THE LABELS OF HOUSEHOLD PREPARATIONS

Dr. DeVita related to the members that he had recently received an offer from Mr. J. M. Turner of Bethany, a new member of the General Assembly, to submit a bill modeled on the New York law. This offer had been conditional on the Committee's agreeing to back the bill actively. Since the deadline for submission of new bills was January 28 and the Committee was not to meet until January 27, it had been agreed that Dr. Fisher would draw up a skeleton bill and turn it over to Mr. Turner with the understanding that Mr. Turner would have it copied on the proper forms and would then hold it until he was telephoned from the Committee meeting and informed whether the Committee had decided to go ahead. If the Committee decided to endorse the bill in principle, Mr. Turner would file it; if it was decided not to do anything about this project at the present time Mr. Turner would tear up the bill. If the Committee did agree to back the bill, Mr. Turner had also offered to approach a Democratic Senator and ask him to file the bill in the Senate, thus making it a bi-partisan matter. Pursuant to this agreement between Drs. DeVita and Fisher and Mr. Turner, Dr. Fisher had mailed Mr. Turner a skeleton bill whose language was taken in part from the New York law; a copy of this bill is appended to this Report.

Dr. Fisher explained that the bill he had drawn up was obviously incomplete in several respects—among others in that the definition of "Poison" had been left blank and no appropriation for enforcement had been provided for. He said that Mr. Turner had clearly understood, however, that if the Committee agreed to back the bill in principle a revised text would be prepared by the Committee and turned over to Mr. Turner to substitute for the original bill before legislative committee hearings were held.

At a conference of those Committee members who could get together the night before the regular meeting, sections of the bill had been read and discussed, but the only specific agreement reached was that a definition of "Poison" in Remington's "Practice of Pharmacy" might serve.

Dr. Dwyer remarked that from the standpoint of public safety they were all agreed that we ought to have a labelling law; this was our opportunity to get something done and we ought to take advantage of it; even if the bill didn't go through this time we would have made a start.

On motion of Hewitt, seconded by Wedberg, it was voted that the Committee approve the idea of such a bill.

On motion of Fisher, seconded by Hewitt, it was voted that a subcommittee of not more than three be appointed to draw up the revised bill. Dr. DeVita appointed Plank (chairman), Hewitt and Fenney.

It was agreed that each member would inform his respective governing board of the action of the Committee and solicit their support.

REPORT OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION ON "ABUSE OF INSECTICIDE FUMIGATING DEVICES"

Dr. Fisher told the Committee that Dr. Hewitt had forwarded to him a reprint of the above name which had appeared in the October 9, 1954 issue of the *Journal of the American Medical Association*. Dr. Fisher thought it should be called to the members' attention because it supported so well our opinion of lindane vaporizers as expressed in the action taken at the December 4, 1952 meeting. The report should be read in its entirety, but the final paragraph is worth quoting:

"Insecticidal poisons that are effective because of deliberate continuous pollution of the atmosphere have questionable safety. Their use in this manner is contrary to hygienic standards for safe atmospheric living and working conditions. The Committee wishes not only to reaffirm its opposition to the home use of continuously operating devices (insecticide vaporizers) but also to reemphasize its warning that extreme care is required in the intermittent use of such equipment promoted as so-called insecticide fumigators."

Dr. DeVita remarked that a lot of lindane was used on animals in the summertime, and the possibility existed that children handling these animals might absorb some of the insecticide.

THE CONNECTICUT STATE MEDICAL SOCIETY

extends greetings

To the Member Hospitals of the Connecticut Hospital Association

in observance of

NATIONAL HOSPITAL WEEK — MAY 8-14, 1955

*Your administrative, medical and nursing staffs have achieved a tradition of community service without equal.

*Your policies of management have maintained high standards of patient care despite the difficult operating problems you have been required to meet.

*Your teamwork with medical and nursing staffs has helped reduce the average patient stay of 35 days in 1900 to 8 days in 1955.

*Your insistence on high standards has won for each member hospital recognition by the Joint Commission on Accreditation of Hospitals.

The people of Connecticut are therefore assured that their community hospitals meet the exacting professional standards of the American Hospital Association, the American Medical Association, the American College of Physicians and the American College of Surgeons.

PUBLIC RELATIONS

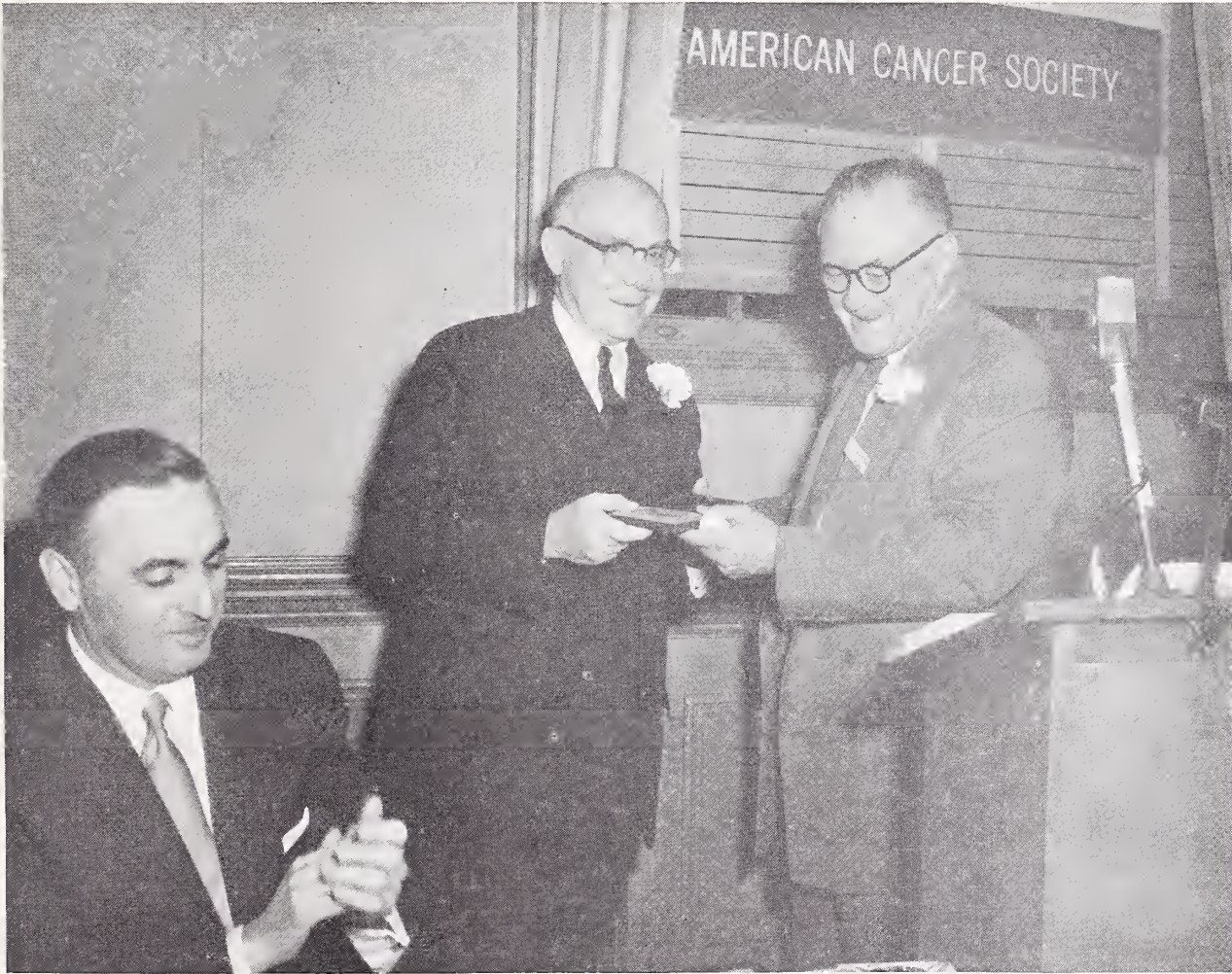
COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington
Chairman
Harold A. Bergendahl, Norwich

Burdette J. Buck, Hartford
James C. Canniff, Torrington
Morris A. Hankin, New Haven

Harry C. Knight, Middletown
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Alfred J. Sette, Stamford

DR. BARKER RECEIVES CANCER AWARD



Dr. Creighton Barker, executive secretary of the State Medical Society, center, is shown receiving the 1955 medal for distinguished service in cancer control from Dr. Ashley W. Oughterson, president of the Connecticut Division, American Cancer Society.

Governor Ribicoff is shown applauding during the ceremony, held as a feature of the annual campaign dinner of the organization March 30 in Hartford.

The honor is conferred by vote of the executive committee of the Division and is the State cancer group's highest annual award.

Dr. Barker has been actively associated with the work of the cancer organization since he served as

one of its original incorporators eighteen years ago. In 1947 he was named president of the division and served in that capacity for two years. He is currently a member of the organization's Medical Advisory Committee and chairman of the Committee on Fellowship Awards.

New Health Education Series on WKNB-TV

"Accent on Living," a series of 13 weekly television programs aimed at better living through proper use of modern health knowledge and services, is being produced as a public service from the studios of WKNB-TV, New Britain.

The new series was initiated April 7 and the weekly programs are being telecast each Thursday at 3:15 P. M. The series of 15 minute programs is being produced by the Connecticut TV Committee for Health Education, which comprises representatives from the State Medical Society, the State Health Department, 12 statewide voluntary health agencies and four television stations.

One of the programs in the series to be produced by the State Medical Society is scheduled for May 26. Entitled "When The Doctor Comes To Your House," the program will be produced in cooperation with the Hartford County Medical Association.

Other subjects to be included in the series are home accident prevention, rehabilitation of the handicapped, rheumatic fever, tuberculosis, cancer and arthritis.

Greenwich Medical Society Sponsors Community Information Program

The Greenwich Medical Society has inaugurated a progressive program to inform community residents concerning the objectives and services of the Association.

Published in *Greenwich Time*, daily community newspaper, the information is contained in a four-column by three-inch advertisement of the institutional type.

The copy reads as follows:

"The Greenwich Medical Society includes in its membership of sixty members nearly all of the practicing physicians in Greenwich. It strives to improve relations between its members and the communities they serve. Monthly meetings are held, some for business purposes, some with programs of a scientific nature. Public health problems are discussed.

"The Society is one of the sponsors of the popular Medical Forum.

"Representatives are selected to consult and serve with different groups, including the Community Chest, the Greenwich Health Association, the Health Committee of the Representative Town Meeting.

"The Society has arranged for Emergency Service.

Any person who is ill and does not have a regular physician can obtain prompt aid by phoning the Physicians' Exchange, Greenwich 8-5800, at any hour."

Community Groups Show Continued Interest in Medical Films

A recent report indicates continued popularity of two AMA films now available without cost to community organizations.

During the month of February these two films, "Your Doctor" and "Operation Herbert," were shown at the Central School in Simsbury, Winsted Y. M. C. A., and other community groups in Poquonock and Bridgeport.

The films are available through the offices of the State Medical Society free of charge other than postage. Because of continued demand, it is necessary that the films be reserved well in advance of meeting dates.

Standard Listing of Emergency Plans

A program to standardize the listing of emergency plans in telephone directories has been initiated by the Society's Public Relations Committee.

The project is being undertaken in cooperation with the Public Relations chairmen of county medical associations. First step is a survey to determine the type of listing now being used by each plan.

The purpose of the project is to make telephone numbers of the plans more readily accessible. In a number of communities, local medical associations have already met the problem by inserting a notice in bold face type in the physicians and surgeons section of telephone directories.

Hartford County Initiates Opinion Survey

An opinion survey of community residents concerning problems of medical care has been initiated by the Hartford County Medical Association in cooperation with the Hartford Branch of the University of Connecticut.

New Britain, Wethersfield and Bloomfield have been selected as typical communities for the survey to assure an adequate cross section of opinion. Approximately 40 university students will participate in the survey before its completion. The project will comprise 350 interviews, the results of which will be recorded on a specially designed questionnaire containing 25 questions.

MEDICAL ADVISORY COMMITTEE TO CONNECTICUT STATE WELFARE DEPARTMENT

EDWIN R. CONNORS, *Chairman*

Pharmacy Program of State of Connecticut Welfare Department

Supersedes statement transmitted January 15, 1951.

To all concerned practitioners of the healing arts, and all pharmacists:

An Advisory Committee of the State Medical Society and a similar Committee of the Connecticut Pharmaceutical Association have reviewed certain aspects of our pharmacy program and have approved the following recommendations, which are accepted and made effective as of this date (December 1, 1954):

1. No prescription shall be refilled, if payment is expected from the State, except upon the definite order of a physician, either written or oral.

2. All prescriptions, either written or oral, shall include the following instructions:

- a. The number of refills permitted, and
- b. The termination date of the prescription.

(For example: "Refill 4 times, but not after March 17, 1955;" "N.R.," indicating no refill; etc., etc.)

3. No charge shall be made by the practitioner for his order, written or oral, that a prescription be refilled.

4. For medications dispensed by the practitioner in office or home visits, when pharmacies are remote or prescription is impracticable, he will be paid by the State at cost to the physician. Prescriptions will be employed wherever practicable.

5. Our medical care program is based upon provision of the adequate minimum, that is, standard, accepted methods of diagnosis and treatment. The prescription of unproved drugs or other therapeutic agents and the prescribing of therapy of an experimental nature are outside the scope of our program, and payment for same cannot be expected.

6. The use of cortisone, hydrocortisone and corticotropin is freed from the restrictions imposed by the Medical Society's recommendations of January 1951. Hereafter these drugs may be prescribed without requesting prior authorization, according to

standard, accepted practice: namely, in the smallest effective dosage, "just enough to make the disease bearable. To give large doses is often to get the patient into trouble." (Hench, Cecil, Alvarez.)

7. Vitamins will be prescribed only in accordance with the recommendations of the Council on Pharmacy of the American Medical Association, namely, in cases of apparent vitamin deficiency. Expensive, high potency multivitamin preparations may be prescribed for treatment of specific conditions only, not for maintenance.

8. The prescription of the expensive, broad-spectrum antibiotics is authorized only when they are definitely necessary. Prescription of simpler medications, when adequate, may save not only considerable tax money but also the possibility of sensitization of the beneficiary. According to the AMA Council on Pharmacy, penicillin is still the most generally effective of all the antibiotics.

9. Prescription of narcotics or habit-forming drugs for the subjects of drug addiction is disallowed except as a lifesaving measure or in similarly profound emergency. It is noted that there is an unofficial opinion by the Attorney General that payment for such drugs cannot be made from public funds.

10. As approved July 1, 1949 by the Executive Committee of the State Medical Society's Council, the State will not authorize payment for alcoholic liquors prescribed for its beneficiaries.

11. The attention of practitioners and pharmacists is called to the fact that an allowance is made to the individual beneficiary of the Welfare Department for the purchase of so-called "medicine chest" items, and except in extraordinary circumstances these should not be prescribed. Such items include cathartics, such as milk of magnesia, epsom salts, seidlitz powders, alophen pills; normal amounts of first-aid supplies, gauze, band-aids, adhesive tape, bandages, cotton, small amounts of antiseptics (iodine, peroxide, merthiolate); commonly used ointments, such as zinc, boric acid, ammoniated mercury, vaseline; remedies not usually purchased on prescription, such as soda bicarbonate and as-

pirin; proprietary preparations of the nature of Vicks Vaporub and Musterole; toilet preparations, such as rubbing alcohol, witch hazel, corn preparations, dusting powder, kleenex; substitutes for foods, such as saccharin; and such items as douche syringes, hot water bottles, infra red bulbs, heating pads and thermometers. It is recognized that all these items are not purchasable at one time under the allowance given, but few, if any, households have all these items, and the home medicine chest is geared to the needs of the individual or family.

1954 Had Fewer Deaths and More Births

The number of births recorded in the State in 1954 increased sharply from the previous record reached in 1953, the provisional total 49,379, exceeded the previous year's total by 2,130. The birth rate, 22.2 per 1,000 population, was, with the single exception of 1947, the highest since 1921 and marks the fourth consecutive increase in the birth rate. The recent trend for marriages in the State has continued with a drop from 8.4 marriages per 1,000 population in 1953 to 8.0 in 1954. The marriage rate has been declining since 1946 with one slight increase recorded in 1950. The continued increase in the birth rate in spite of a continuing decline in the marriage rate is unusual when compared with Connecticut's past experience.

NEW LOW SET FOR DEATHS

The mortality experience for Connecticut in 1954 reached a new low. There were 20,274 deaths recorded in the State for the year, or 9.1 deaths per 1,000 population compared with 9.5 in the 1953 and the previous low of 9.4 established in 1949 and repeated in 1950.

INFANT AND MATERNAL MORTALITY

Infant mortality for 1954, 22.1 deaths under 1 year of age per 1,000 live births marked the third consecutive increase since the all-time low of 20.6 which was recorded in 1951 and the highest reached since 1949 when 23.1 of 1,000 infants born alive died during the first year of life. The reduction in infant mortality which has been accomplished even during the past 10 years has been remarkable and any indication that mortality among infants within reasonable limits of chance variation from the average mortality is increasing is noticed with concern. Present infant mortality remains rate for the past five years, 21.4.

Maternal mortality, 3.0 deaths per 10,000 live

births decreased slightly from the 1953 rate, 3.4, but remained above the low ratio of 1.8 and 1.9 established in 1952 and 1951, respectively.

COMMUNICABLE DISEASES

Pneumonia, all forms, the leading cause of death among the communicable diseases since 1951 was responsible for 345 deaths in Connecticut in 1954. The death rate, 15.5 deaths per 100,000 population, the third lowest ever recorded, decreased considerably from the rate, 18.0, in 1953. Tuberculosis, the second leading cause of death among the contagious diseases set a new low record for the ninth consecutive year with a rate of 7.2, less than one-half of the rate for 1950 and one-fourth the rate for 1946.

Polio-myelitis and meningococcal infections were responsible for 11 and 9 deaths, respectively, compared with 19 and 18 in 1953. There were no deaths recorded from typhoid fever and diphtheria during the year and 2 deaths each from streptococcal sore throat (including scarlet fever) and whooping cough. The deaths from whooping cough were the first to occur in the State since 1950 when 3 were recorded.

CHRONIC DISEASES

The 1954 death rate from diabetes, 15.7 from 16.9 in 1953, was the lowest ever recorded for the State. Reductions in death rates from 1953 levels were also observed for diseases of the heart, 382.4 compared with 396.7; vascular lesions affecting the central nervous system, 96.4 from 102.0; and diseases of the arteries, 21.3 compared with 24.3. Mortality from heart disease was the lowest recorded since 1949 and from vascular lesions since 1950, while that for diseases of the arteries has not been lower since 1939. Cancer mortality, 172.1, increased slightly from the level 171.0 established in 1953 but remained below that for 1952.

EXTERNAL CAUSES OF DEATH

The 1954 death rate from all accidents, 39.8 from 43.3 in 1953, was also the lowest ever recorded for the State. A decrease in motor vehicle fatalities was partially offset by an increase in mortality from accidents in the home, accident rate 19.7 for 1954 increasing 3 per cent from that for 1953. Suicide, 11.1, increased slightly from 10.4 in 1953, while a decrease was observed for mortality from homicide, 1.0, compared with 1.5 for the previous year. The death rates from these causes remain the lowest on record.

FROM OUR EXCHANGES

"Unilateral Renal Disease and Hypertension" is the title of an interesting discussion of hypertension by Burns (*Cal. Med.*, 79:4, pp. 415-419). The author calls attention to the fact that cures are obtained in about 20 per cent of patients with unilateral renal disease and hypertension who have nephrectomy primarily for hypertension. He believes that it would be profitable to carry out urologic studies in a larger number of hypertensive cases in the hope that the condition might be traced to renal disease. In the author's opinion renal angiography more accurately indicates the renal origin of hypertension than does any other diagnostic study. If a unilateral renal condition is discovered as a possible cause of hypertension, nephrectomy should be done unless there is some general contraindication to an operative procedure.

* * * *

In a discussion of "Upper Respiratory Infections in Infancy" by Norman (*The Practitioner*, 171:1026, pp. 601-607) attention is called to the fact that tracheotomy is sometimes life saving in acute laryngo-tracheo-bronchitis. The author agrees that it is sometimes difficult to determine when the operation should be performed. In general his indications are that tracheotomy should be performed when there is considerable respiratory distress in a patient that is not responding to treatment. Tracheotomy is urgently necessary when there are indications of cyanosis. The operation carries with it considerable risk and should not be performed if the respiratory symptoms are mainly due to bronchial involvement and pneumonia. Preparation for tracheotomy should be made in every case in which there is rib recession, and it probably is better to err on the side of too early intervention.

* * * *

Thompson relates in considerable detail his experience with the techniques of the operation in which a vitallium intramedullary hip prosthesis is substituted for the diseased hip. Of 25 cases operated on, 19 showed satisfactory results. There were four failures in the series. In two cases the results were equivocal. As the result of experience the complications leading to unsatisfactory results can be drastically reduced.

The operation should not be used indiscriminately. The primary indication for prosthesis is the aged person with nonunion of a femoral neck fracture in which absorption of the neck has taken place. A second indication are those conditions in which painful hips due to aseptic necrosis of the femoral head following union of a fractured neck of the femur still retain a good acetabular socket with minimal arthritis visible in the roentgenogram. A third indication is that group of patients with severe arthritis in both hips in which arthrodesis of one hip is contemplated and some type of reconstructive procedure is needed for the other hip. The primary use of prosthesis for fresh fractures of the hip is controversial. The use of prosthesis for painful degenerative arthritis of the hip is a reason for thought and speculation.

In this series of 25 cases there have been no deaths as a result of the operation. There has been one acute dislocation with infection. There has been no breakage of the prosthesis (*Tex. State Jour. of Med.*, 49:10, pp. 749-756).

* * * *

A friendly discussion of "Why I Entered Rural Practice" is always of interest. Saltzman makes the entirely frank answer that "I needed to make a living" (*Jour. Arkansas Med. Soc.*, LI:4, pp. 92-95). When the author came out of the Army the town of Mountain Home offered him an equipped office, a home and a car if he would settle in their town.

He seems to have never regretted the choice of location. Almost at once he found himself in a community where he was wanted. Most of the promises of an office, of a home and of a car were not kept. However, the people were friendly and in no time at all he was the family doctor. He soon discovered that this practice grew and so did his problems. He calls attention to the fact which always amazed and delighted him "was the large variety of illnesses and accidents that came my way. I learned a lot of medicine in a short time. I had to." He warns that you should never sell the country doctor short, for "he knows a great deal of practical medicine and usually has an up-to-date library." His list of advantages in rural practice are the friendship and respect of patients, a pleasant environment, unlimited op-

portunities for varied practice and self improvement, economic security, participation in civic and community affairs, less "cut-throat" competition, and the opportunity for recognized services to humanity.

Dr. Saltzman has found a town of his own; and likes it.

* * * *

Blood transfusions probably in many instances are ordered too easily. Hall's discussion of the "Use and Abuse of Blood" is welcome and timely. We do not have to agree with all his conclusions which are briefly summarized as follows (*Northwest Med.*, 53:9, pp. 893-896):

(1) Whole blood, and to a lesser extent blood fractions, due to availability and ease of administration, are being widely used—and not always wisely.

(2) Ordering blood which is not likely to be used is a common abuse as blood deteriorates through handling and lack of refrigeration.

(3) The use of blood transfusion as a tonic for so-called cosmetic reasons is to be condemned.

(4) The primary use of whole blood from the surgeon's viewpoint is that of maintaining or restoring blood volume following hemorrhage, severe trauma or burns.

(5) Another important use involves improvement of oxygen transportation as in severe anemia. Here the treatment should be directed to the bone marrow (if there is a functioning bone marrow) and not to the circulating blood. In such circumstances packed red blood cells is urged in preference to whole blood.

(6) Further use of whole blood or blood fractions include the provision of clotting factor in hemorrhagic states, immune antibodies, restoration of colloid osmotic pressure in hypoproteinemia, protein nutrients, and in replacement of abnormal blood.

(7) Blood is potentially a lethal commodity, requiring precise care in its preparation and use. Hemolytic reactions and circulatory overload are the most common dangers. The author lists other less common dangers.

(8) Mismatched transfusions must be diagnosed immediately and treated promptly to prevent death from renal shutdown.

(9) Circulatory overload resulting in cardiac fail-

ure is more common than is usually appreciated and must be watched for, especially in elderly people (and small infants).

(10) Whole blood depresses bone marrow activity to the point where such inhibition of red cell regeneration usually more than offsets any temporary advantage gained through transfusion, unless the latter is specifically indicated.

* * * *

"Cancer of the Genito-Urinary Tract" is the subject of a thoughtful discussion by Lewis (*Rocky Mt. Med. Jour.*, 51:9, pp. 789-797). If there is absence of symptoms Dr. Lewis concludes that there is no acceptable method of early diagnosis of cancer of the kidney cortex. Early palpable tumors of the kidney pelvis, ureter or bladder can be detected by thorough urologic investigation of every patient with microscopic hematuria. If the suspicions of the urologist are aroused, an early diagnosis of cancer of the urethra and penis can be made. The diagnosis of testicular tumor would be made earlier if physicians were aware of the relative frequency of this malignancy in young men and were trained in the simple method of bimanual palpation of the testes. There are no symptoms of early prostatic malignancy; and the only method of detecting early operable cancer of the prostatic gland is by digital rectal examination.

* * * *

Kimmelstiel-Wilson disease consists of a conspicuous correlation between the clinical syndrome diabetes, edema, albuminuria, and hypertension on the one hand and a particular type of intercapillary glomerulosis found on examination of pathologic sections of the kidney. Fawcett reports "Observations on Insulin Requirements of Kimmelstiel-Wilson Disease" (*Jour. Lancet*, 74:9, pp. 327-330). The subject as presented is of interest in the one case cited as an illustration of the transition from an unusually high to a very low insulin requirement in a relatively short period of time. The cause of insulin resistance in these cases is not known. In certain cases of insulin resisting antibodies have been demonstrated. The apparent amelioration of diabetes, in terms of insulin requirements, and the absence of ketosis in the presence of the Kimmelstiel-Wilson type of renal lesion depends on a basic metabolic defect that up to the present time has not been explained.

Moyer and Buthcher state that in so far "as the etiology of peripheral vascular disease is concerned, nothing at present is really known excepting that the use of tobacco is related specifically to the development and progression of Buerger's disease. Pathologically peripheral vascular diseases have been misnamed, for they are, with minor exceptions, generalized diseases of the vascular and collagenous system" ("Peripheral Vascular Disease," *Jour. Iowa State Med. Soc.*, XLIV:10, pp. 463-469). Clinically the most common serious conditions resulting from venous disease of the lower extremity are: 1. chronic brawny edema, 2. pigmentation and atrophy of the skin, 3. extreme subcutaneous fibrosis, even occasionally calcification, 4. ulceration, and 5. secondary varicosities, all involving primarily the distal portion of the leg. Uncommon entities usually considered in the peripheral vascular category are erythromelalgia, livido reticularis, acrocyanosis and faux panaris.

The only treatment suggested by the authors is (1) the wide and total excision of the atrophic skin and underlying fibrous tissue down to the normal structures, followed immediately by split-thickness graft, and (2) constant postoperative elastic support in an attempt to control any tendency toward edema.

* * * *

An accuracy of over 95 per cent is claimed for cholecystography by the method followed by Mauthe ("The Accuracy of X-ray Examinations of the Gallbladder," *Wisconsin Med. Jour.*, 53:9, pp. 473-476).

Telepaque in a dosage of six tablets is regularly employed as the contrasting medium. Castor oil is given five hours after the Telepaque tablets to many patients. On the following morning films are taken in the horizontal position with the use of the Bucky diaphragm. If the gallbladder is not visualized in these films, the entire examination is repeated within the day or two (no castor oil).

Dr. Mauthe believes that "the formation of stones appears to be the primary pathologic condition in the gallbladder and cholecystitis is probably the result of cholelithiasis instead of the cause of it." We are allowed to have our reservations as to accuracy of this last observation. However, we are inclined to accept his assertion that normal cholecystograms are never obtained in the presence of significant gallbladder disease—stones, carcinoma, or surgically

significant cholecystitis. The author admits that some error will occur when the method is applied to the normal gallbladder. He adds that "if proper attention is given to the x-ray findings in patients with possible gallbladder disease, the number of normal gallbladders removed will be reduced to a small figure."

* * * *

Pancreatitis, according to Zollinger *et al.*, is now considered a frequent cause of both acute and chronic abdominal pain (*New Eng. Jour. Med.*, 251:13, pp. 497-502). The variable and sometimes bizarre manifestations of the disease often cause it to be confused with many other common abdominal disorders. Alertness on the part of the examiner and a laboratory confirmation are necessary for an accurate diagnosis. The single most important diagnostic aid is a blood amylase determination obtained within the first 48 hours. In suspected cases of longer duration with equivocal or normal blood amylase values, analysis of peritoneal fluid obtained by a simple abdominal tap will often establish the diagnosis. There are other aids to diagnosis such as finding a "sentinel loop" or segmented ileus, displacement of surrounding viscera, gallstones or calcifications in the pancreas on roentgenologic examination.

Blood volume studies on patients with all types of pancreatitis have shown an impressive and frequent deficit.

The optimum management of the acute phase of pancreatitis is conservative. The blood volume deficit is immediately replaced. The pancreas should be placed at physiologic rest. Vagus blocking drugs (demerol preferred to morphine) and diet (food withheld and gastric suction used to remove gastric secretion) should be directed toward inhibiting the mechanism of pancreatic secretion. Demonstrated biliary tract disease should be corrected after the acute episode has subsided. Individualized surgical approach is indicated in chronic pancreatitis.

* * * *

Emesis and hiccough, according to Stewart and Redeker, are usually effectively controlled by the use of Thorazine (*Cal. Med.*, 83:3, pp. 203-205). The drug was more effective when given intramuscularly than when administered by the oral route. It was used intravenously once; shock occurred soon after the injection. The dose given intramuscularly was commonly 25 mg.

NEWS FROM WASHINGTON

Reinsurance

WHAT BILLS WOULD DO

This legislation provides an initial \$25 million to start a trust fund that would be maintained by percentage payments from premiums of participating health insurance plans. The total U. S. contribution would be \$100 million. The fund would reimburse voluntary health insurance plans (commercial and nonprofit) for abnormal losses in extending coverage and expanding benefits. Cited by the Administration bill as areas where reinsurance would be helpful are catastrophic illness and coverage of rural families and low income groups. Participation would be voluntary on the part of insurance companies.

STATUS OF BILLS

Chairman Priest of the House Interstate and Foreign Commerce Committee has said hearings will be held on this subject, but no date has been set. Chairman Hill of the Senate Labor and Welfare Committee has not indicated an interest in the bill nor is there strong support apparent among members generally. The Administration, principally through the President and Mrs. Hobby, has made plain that it will press hard for reinsurance, which has been identified as at the top of the White House "must list" for health legislation. The bill is little changed from last year's measure which was defeated in the House. Bills before this Congress: Title I of the following Administration omnibus health bills: S886 (Smith of New Jersey and 8 others), HR3458 (Priest) and HR3720 (Wolverton), also HR400, 401, and 2533 (all by Wolverton).

AMA POLICY

While indorsing the stated purposes of the bills (to promote the best possible medical care on reasonable terms), the American Medical Association again opposes the proposal on the grounds that (1) extensive private funds are available within the insurance industry for such purposes, (2) reinsurance doesn't provide a means for making insurable what otherwise would be an uninsurable risk, (3) it will not fulfill its intended purpose and might even inhibit the satisfactory progress made to date by voluntary plans, and (4) it is a potential subsidy.

Doctor Draft Extension and Military Medical Scholarships

WHAT BILLS WOULD DO

The Doctor Draft extension bill would continue the present act for another two years beyond its July 1, 1955, expiration date. Under the scholarship bill the government would pay up to \$133 per month, plus tuition and fees. Students would be obligated for three years' active duty if the scholarship was for a year or less, and four years if for more than one year. The Defense Department is proposing this plan as part of its long range program for procuring career medical officers; an extension of the Doctor Draft is its answer to the short range problem.

STATUS OF BILLS

The Doctor Draft issue is almost certain to come up for Congressional action, because of the imminent expiration of the act that for four and one-half years has supplied the military with physicians. Hearings have not yet been scheduled, however. It is planned to bring up scholarship bills ahead of draft extension. The three services have been supporting an extension for the last year, and eventually the Defense Department accepted this policy, making the present bill an official Administration measure. Doctor Draft bill is HR2886 (Vinson); scholarship bills, HR67 and HR4645 (Bennett, Florida) and S1444 (Russell and Saltonstall).

THE AMA POLICY

When there was a proven need for it at the start of the Korean War in 1950, the Doctor Draft was supported by the AMA. The AMA also supported one extension of the law. Now, in the face of the Defense Department's request for another (and peacetime) extension, the AMA's policy is unchanged. If it can be demonstrated that there is a continuing need for the act, the AMA will support the extension. Evidence so far presented has not established the need. The Defense Department admits the regular draft obligation will supply it with the young physicians it needs, but says that the Doctor Draft is required to bring in more experienced men with special skills and administrative

ability. Without these, the Department insists, the military medical services cannot be maintained during the next two years. The AMA believes the services could do a great deal more to build up their regular Medical Corps and to make more efficient use of the experienced men now in uniform. The AMA supports the scholarship idea, provided that (1) a student not be approached by the military until he is fully matriculated in the medical school, (2) no student so selected received any preferential treatment, and (3) number of military scholarships in a school not exceed 5 per cent of any year's class or the total enrollment.

AMA Urges Approval of Civil Defense Funds

American Medical Association has urged House and Senate Appropriations Committees to approve funds for medical activities of the Federal Civil Defense Administration. In identical letters to chairmen of the two committees, AMA Secretary and General Manager George F. Lull stated it was futile to plan for the medical phase of civil defense unless the profession "has available the supplies necessary to perform its work." He added: "It is essential that sufficient funds be authorized for the stockpiling of necessary medical supplies and equipment if we expect to sustain the interest of the profession and to utilize physicians advantageously in the event of a disaster." For fiscal 1956, the administration has asked Congress for \$35.3 million to run FCDA, an increase of nearly \$10 million over funds available for this fiscal year.

Mental Illness "Greatest Health Problem"

According to a special Hoover Commission Medical Task Force report, mental illness is the greatest single problem in the nation's health picture. Prepared by Task Force member Dr. Francis J. Braceland of Yale University, it is the basis of Commission recommendations on mental health made to Congress. If the present rate of mental illness continues, the report states, one in every twelve children born in the U. S. will spend some time in a mental institution, with about 250,000 persons being admitted this year. It cites the lack of trained personnel as the "most serious bottleneck" in the way of proper care for mental cases.

House Reduces Budget for HEW For Next Fiscal Year

Well ahead of last year's schedule, the House on March 21 voted an appropriation of \$1,907,403,361 to run the Department of Health, Education and Welfare for the fiscal year beginning next July 1. Last year it was June 10 before the House approved the HEW budget. The bill has been sent to the Senate where hearings begin soon before an Appropriations subcommittee headed by Senator Hill (D—Alabama). The bill as recommended by the House Appropriations Committee on March 18 and approved by the House is \$42,062,500 under what the administration has requested and \$118,772,714 under what the 83rd Congress had voted for the current year.

Approximately 75 per cent of the entire budget is made up of public assistance grants to the States (\$1.4 billion), including an unspecified amount for medical bills of public assistance recipients; this year an estimated \$80 million will be used for this purpose, and the administration has asked for another \$20 million in the event Congress approves its matching formula plan.

Major health items voted by the House:

HILL-BURTON HOSPITAL AND CLINIC PROGRAMS

A total of \$96 million divided \$75 million for the regular program (the administration asked for \$65 million) and \$21 million for the expanded program for clinics, rehab centers and nursing homes (the administration wanted \$60 million). The committee said part of the \$21 million voted by the last Congress for the new program would not be used before June 30 and would be available for the next fiscal period.

NATIONAL INSTITUTES OF HEALTH

A total of \$89,138,000, the amount requested, was arrived at by cutting \$1 million for water pollution control and adding \$750,000 for research in mentally retarded children and \$250,000 for 26 additional neurology and blindness beds to the Clinical Center at Bethesda.

OFFICE OF VOCATIONAL REHABILITATION

Voted \$35,300,000, a reduction of \$7,273,000. As in case of Hill-Burton, the committee found OVR plans for expanded program overly ambitious and

said the program "might well be done more harm than good" by too rapid expansion.

OTHER PROGRAMS

\$34,026,000 for PHS hospitals and medical care, including care for seamen; \$33,840,000 for Indian health activities, after July 1 a responsibility of PHS instead of Interior Department; \$30 million for Children's Bureau maternal and child welfare grants to States; \$12 million for general assistance to States; \$5,484,000 for Food and Drug Administration; nothing for PHS Civil Defense activities, as the committee said it was "confusing and wasteful" for civil defense budgets to be scattered among a number of agencies. It proposed a unified civil defense budget.

House Votes \$750 Million Medical Budget for Veterans Administration

The House on March 30 approved a Veterans Administration medical budget of around \$750 million for the fiscal year, starting next July 1. Backing up its Appropriation Committee, the House agreed to \$16,885,000 more than was requested for a start on rebuilding of some VA hospitals. VA asked Budget Bureau approval of \$20 million for this purpose, the bureau cut it to \$13,815,000 and the Committee raised it to \$30 million. Commented the committee on its action: "The whole purpose of the modernization of older hospitals is to bring the present plan up to date instead of building new and additional hospitals."

Other medical-hospital items approved (current appropriation in parenthesis): inpatient care, \$619,000,000 (\$593,992,500); outpatient care, \$82,089,000 (\$82,134,000); hospital and domiciliary facilities, \$30,000,000 (\$47,000,000); medical administration and miscellaneous operating expenses, \$15,294,000 (\$14,654,000). Total VA budget for the next year is \$4,463,126,000 which includes \$2.8 billion for compensation and pensions.

Hoover Commission Cites Weakness in Federal Lending

Without making reference to administration proposals for health reinsurance and mortgage loan guarantees for health facilities, the Hoover Commission in its report to Congress on lending agencies warns of weaknesses "inherent" in government lending. They include: (a) tendency of such agencies to expand functions beyond original purposes, and

to try to remain in business after their functions are completed, (b) a trend toward creating activities that could be undertaken by private agencies, and (c) presence in some agencies of concealed subsidies.

These observations were included in the report as comment, rather than as recommendations. Recommendations dealt with changes in present lending agencies and operations. Neither the Commission nor its Task Force on Lending, however, was critical of the philosophy of federal loans, and the Commission noted that in general "these agencies have developed methods of organization which assure integrity, efficiency and great public service."

For Bricker and Tax Relief

The trustees' stand on pending legislation, made public last week by AMA Washington office, discloses that the stamp of approval—when used at all—has been put chiefly on bills giving self-employed physicians income tax relief, encouraging membership in voluntary health insurance plans and restricting the President's treaty making powers (Bricker Resolution). Approval was given the latter to "provide protection against the type of 'back door' medical legislation now possible."

Democratic Bills Okayed

Unqualified approval was given the Hill-Priest bill (SJ Res.46—HJ Res. 256) authorizing funds for a national inventory of mental illness problems, to be conducted under non-Federal auspices. Also approved was S1323, by the same Democratic sponsors, to make construction grants to medical schools. Indorsement of latter, however, is conditional upon appointment of an all-professional advisory council and elimination of the incentive to schools to increase their enrollments.

A minor upset was recorded when trustees opposed Hill-Bridges-Priest bill (S849—HR3459) on Federal construction grants to stimulate medical research. AMA's committee on legislation reportedly indorsed this measure but was overruled by trustees, who branded the bill "too broad and loosely written."

Social Security Coverage

Trustees' report expresses "active opposition" to compulsory coverage of physicians by social security but "no opposition" to voluntary inclusion. It opposes bill (SJ Res. 19) that would transfer Bureau

of Narcotics to Justice Department; withholds action on S9, establishing contributory health insurance for Federal employees, presumably because this bill will soon be supplanted by one more carefully drawn, and rejects most of the pending measures on liberalization of medical care benefits for veterans.

House Committee Votes Mental Illness Study

House Commerce Committee on March 18 approved and sent to the floor where clearance was granted HJ Res. 256, authorizing sum of \$1,250,000 to help finance survey of nation's mental illness problems to be conducted by one or more non-governmental organizations. This is a "clean bill," based on HJ Res. 230. Sole change, made at behest of HEW Department, makes it clear that groups doing survey must coordinate their own activities, rather than depend upon Public Health Service for this chore. Rep. William L. Springer (Illinois), a conservative Republican, has joined with Rep. J. Percy Priest (D-Tennessee) as a sponsor for the 3 year mental survey plan.

Institute of Aviation Medicine May Be Sought

Rep. J. Percy Priest (D-Tennessee) is working on a bill for establishment of an Institute of Civil Aviation Medicine. He made the disclosure in an address at concluding session of first annual meeting of Civil Aviation Medical Association. House Commerce Committee, of which he is chairman, handles legislation dealing with commercial and sport aviation and national health problems.

Washington also was host in March to 26th annual meeting of Aero Medical Association, with a 3 day program devoted to scientific papers and exhibits. The 1956 meeting will be held in Chicago April 16-18.

Gen. Hays Becomes Army Surgeon General June 1

Maj. Gen. Silas B. Hays, nominated by President Eisenhower March 11 to be Army surgeon general, is scheduled to assume his new post June 1. He succeeds Maj. Gen. George E. Armstrong who retires after 29 years Army service to become associate

chancellor and medical activities coordinator of New York University. Gen. Hays, a native of St. Paul, Minnesota, received his medical degree from the University of Iowa in 1928, and after interning at Letterman General Hospital in San Francisco, received a commission in the regular Army in 1929. He was chief of medical supplies in Europe during World War II and surgeon of the Japan Logistic Command during the Korean War.

Servicemen's Dependents Total Nearly 2.6 Million

Department of Defense has taken a census of dependents of military personnel. When and if House and Senate committees conduct hearings on medical care benefits, the figures gathered in the worldwide survey will undoubtedly have an important bearing on the outcome of this legislation. As of December 31, 1954, when active duty armed strength was 3,180,532, dependents of Army, Navy, Air Force and Marine Corps personnel numbered 2,591,777, according to DD's count. By geographic distribution, 2,204,316 were inside continental U. S., 118,632 were in territories and possessions, and 268,829 were in foreign countries.

These comprised spouses, minor children and parents dependent upon the serviceman (or service-woman) for at least one-half of their support. Administration's dependency care bill (S934) would cover a somewhat greater number, since it also includes parents-in-law as eligible beneficiaries.

DATA ON FAMILY UNITS

In 464,721 instances, the wife was listed as sole dependent. There were 319,269 family units consisting of wife and one child; 233,208 with wife and two children; 99,011 with wife and three children, and 47,421 with wife and four or more. Dependents were divided as follows: 1,163,630 wives; 1,573 husbands; 1,306,497 children, and 120,077 parents. Enlisted personnel reported 1,941,228 dependents; officers, 650,549.

STATISTICS BY SERVICES

Army dependents totaled 1,008,564-803,445 in U. S. proper, 57,620 on other American soil, and 147,499 in foreign lands. In same order, Navy reported 579,499 and 28,221 and 24,421 (total 632,141); USAF, 688,453 and 28,798 and 95,644 (total, 812,895); USMC, 132,919 and 3,993 and 1,265 (total, 138,177).

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Newell W. Giles, Darien
President-Elect, Mrs. Norman J. Barker, Collinsville
First Vice-President, Mrs. J. ALFRED WILSON, Meriden
Second Vice-President, Mrs. Frank L. Polito, Torrington

Recording Secretary, Mrs. Charles Culotta, Hamden
Corresponding Secretary, Mrs. C. Murray Gratz, Cos Cob
Treasurer, Mrs. Joseph Woodward, New London

Report of the President of the Woman's Auxiliary to the House of Delegates

As president of the Woman's Auxiliary to the Connecticut State Medical Society I am happy to bring to you the report of our year's activities.

Keeping in mind the theme adopted for County, State and National Auxiliaries this year, "Leadership in Community Health," we have sought to emphasize the importance of our role in the community, both as Auxiliary members and as individuals. Believing too, that to effectively carry on our work we all need spiritual guidance, we agreed that all meetings should be opened with a prayer, and the Lord's Prayer, being of universal appeal, was chosen.

The year 1954-55, the eleventh year in the life of our Auxiliary, comes to a close with a membership of 1,209, an increase of 134 over the preceding year. One county, Tolland, still remains unorganized, but the Auxiliary continues in its efforts to interest the doctors' wives of that county and it is hoped that before long we shall have the privilege of adding Tolland County to our membership.

Our membership dues, together with the generous cooperation of the Connecticut Medical Service and a carefully planned budget, have kept the Auxiliary in sound financial condition.

I shall give you a very brief resume of the work of our various committees.

ART

The Art Committee working with Dr. John Freiheit, chairman of the Physicians' Art Association, planned the annual Art Exhibit which is being held during these three days. This fine exhibit speaks for itself and we all may well be proud of the artistic achievements of our doctors, their wives and children.

AMERICAN MEDICAL EDUCATION FOUNDATION

Of great importance to the members of the Auxiliary is the work of this Committee. More than

\$1,200 was raised this year in the counties through social affairs, appropriations from county and State budgets, and the Memorial Gift Cards.

CIVIL DEFENSE

This committee had a very active year, with its program set up in accordance with suggestions from the State Civil Defense Office, but leaving each county free to use material best adapted to its needs. Many films were made available to the counties and shown at their meetings.

LEGISLATION

Although no specific action was taken on any legislation this year, much lively discussion of current bills before the Legislature took place. Several lists containing most of the bills with medical implications were sent to the Auxiliary for our information.

MEDICAL AND SURGICAL RELIEF

In addition to the collection of medical samples, the committee arranged for the collection of medical journals and textbooks which were distributed through the Darien Book Aid Plan to backward countries and to countries near the Iron Curtain.

MENTAL HEALTH

The Mental Health program, our newest undertaking, has become increasingly important in the Auxiliary as it has in the Medical Society. Films have been shown throughout the State and many of the counties have had speakers on mental health at their meetings. Dr. Lee Bartemeier, chairman of mental health for the American Medical Association, spoke to the members of the committee in January. In addition to several hundreds of dollars donated by the counties to mental hospitals, more than 2,000 gifts were sent to patients.

NURSE RECRUITMENT AND SCHOLARSHIP

Informative literature was distributed through the county chairmen to vocational and career counsel-

lors. While stress was laid on the three-year nursing course and the four-year college course, special emphasis was put on the one-year practical nurse-attendant course which is open to women up to the age of fifty-five. The committee was instrumental in forming several Future Nurse Clubs in the high schools. Counties throughout the State gave eleven nursing and medical scholarships, totalling more than \$2,500.

PUBLIC RELATIONS AND RURAL HEALTH

These two committees which were combined under one chairmanship, working closely with the Medical Society had a very busy year. The most successful project, the Health Exhibits at the Connecticut fairs, was the result of several years' planning. These exhibits were displayed at fifteen fairs throughout the State and thousands of health education pamphlets, including the new First Aid Chart, distributed to the fairgoers. The Auxiliary members assisted the Medical Society in each community where the Emergency Call Exhibit was on display, by keeping the exhibit supplied with literature entitled, "You can get a Doctor." In three counties arrangements were made for the broadcasting of tape recordings: "Hi-Forum" in Fairfield, "The Best is Yet to Be" in Litchfield, and "Chats with Champs," in Middlesex. The members of the Medical Society and the Auxiliary members who assisted in putting out the First Aid Chart were gratified to know that it met with such enthusiasm that Colorado Medical Society and Auxiliary asked permission to reprint it for their exhibit at the Great Western Stock Show and through them interest has been awakened in other States who have also expressed a desire to reprint the First Aid Chart.

SCHOOL HEALTH

The Committee urged all P.T.A. groups to show the film, "School Health in Action," and to appoint health and accident chairmen if they had not already done so. The Auxiliary was represented at all meetings of the Connecticut Advisory School Health Council.

TODAY'S HEALTH

Exhibits were staffed at County Fairs, a State Dental Convention, the Teacher's Convention, the combined Dental Medical Exhibit during Dental Health Week, and the Connecticut Food and Dairy Council. Many sample copies of the magazine were distributed. The State chairman wrote to the Na-

tional *Today's Health* chairman suggesting that the magazine be advertised in newspapers and put on a competitive basis with other magazines, in the belief that it will grow on its own merit when the public is sufficiently aware of it.

THE CONNECTICUT QUARTERLY

This official publication of the Woman's Auxiliary has been published four times this year, with emphasis being placed on meetings of the Auxiliary, county news, reports of the Annual Conference of Presidents and Presidents-Elect, Public Relations and Mental Health. Copies were mailed to every member of the Auxiliary, to National officers and to all State presidents.

THE CONNECTICUT HEALTH LEAGUE

The President-Elect is our official representative to this organization and during the year she attended all the meetings.

THE ANNUAL SCHOOL OF INSTRUCTION

For all State and county officers and chairmen was held in New Haven in June, with former chairmen conducting the round table discussions. A former president, Mrs. F. Erwin Tracy, gave a talk to officers and chairmen on the "History of the Woman's Auxiliary and our Relationship to the National Organization," describing the twelve tools which Auxiliary chairmen need in order to become effective leaders.

THE SEMI-ANNUAL MEETING

Was held at the Waverly Inn, Cheshire, in November. Following the business meeting and luncheon, Dr. H. M. Marvin, your president, spoke to us on "Certain Aspects of Heart Disease."

THE ELEVENTH ANNUAL CONFERENCE OF STATE PRESIDENTS AND PRESIDENTS-ELECT

Was held in Chicago in November. At this Conference which Mrs. Norman J. Barker, president-elect, and I attended, I was a member of the Membership Panel, discussing the subject, "How to Maintain Member Interest."

THE ANNUAL MEETING

Will take place April 27 at the Brooklawn Country Club in Bridgeport. At the close of the business session at which election of officers will be held, Mr. John Hedbach, assistant executive director of the American Medical Education Foundation, will speak on "The Role of the Woman's Auxiliary in A.M.

E.F." Following luncheon, Mrs. George Turner, president of the National Auxiliary, will bring us a message. In order to emphasize further the importance of our role of "Leadership in Community Health" and to inspire us toward greater achievement in the year ahead, we have chosen as our guest speaker, Mrs. Harold Brinig, a member of the staff of the Marble Collegiate Church in New York, who will speak on the subject, "You, as an Individual are Important."

We believe that we have had a good year, but we know that little could have been accomplished without the guidance and encouragement of the members of the Medical Society. I would like especially to mention the names of Dr. Marvin, Dr. Barker, Mr. Burch, Mrs. Lindquist, and our advisors, who were always so willing to discuss our problems with us. We are deeply grateful to you all.

Emma V. Giles

AMA Membership of Physicians Who Move

Prior to June, 1954 a physician who, for any one of a number of personal reasons, found it advisable to move his practice from one State to another was allowed only six months to become a member of the new constituent society before running the risk of losing his AMA membership. Since many component societies have waiting periods of one year, and sometimes more, it became virtually impossible for a physician to join a new constituent society within the six months' period. In recognition of this situation, the House of Delegates amended Chapter II, Section 2, of the By-Laws in June, 1954, to permit a member's name to be continued on the membership roster of the AMA for a period of two years. This added time should obviate loss of AMA membership in all but the most extreme cases.

Although the By-Laws do not spell out administrative detail, the Secretary's Office would remind physicians moving from one State to another that they must pay their AMA dues during the two year transfer period. Forfeiture of AMA membership for nonpayment of dues is provided for in another Section of the By-Laws and was affected by the change in Chapter II, Section 2. Such dues may be paid directly to the AMA Secretary's Office since no constituent society membership exists through which they may be forwarded.

THE DOCTOR'S OFFICE

Maximilian A. Crispin, M.D. announces the removal of his office to 216 Farmington Avenue, Hartford for the practice of gynecology and obstetrics.

Charles E. Jacobson, Jr., M.D. announces the opening of an office for the practice of urology at 172 East Center Street, Manchester.

William J. Stack, M.D. has reopened his office for the practice of internal medicine at 566 Prospect Avenue, Hartford.

Dwight R. Wood, M.D. announces the removal of his office for the practice of obstetrics and gynecology to 140 Retreat Avenue, Hartford.

Presidential Inaugural Ceremony To Be Broadcast

Highlights of the inauguration of Dr. Elmer Hess of Erie, Pennsylvania, as 109th president of the American Medical Association will be broadcast nationwide on Tuesday evening, June 7, during the Association's 104th Annual Meeting. The ceremonies will be held in the Ballroom of Convention Hall at Atlantic City, N. J.

An added attraction will be an address by the celebrated Norman Vincent Peale, D.D., pastor of the Marble Collegiate Church of New York City. Dr. Peale will speak on "The Relationship of Religion and Medicine."

Immediately following the formal inaugural ceremony, a reception honoring Dr. Hess will be given in the American room of the Traymore hotel.

Care of Long Term Patients

The Subcommittee on Hospital Services of the Health Resources Advisory Committee of the Office of Defense Mobilization has issued a report on the problem of reducing the personnel requirements for the care of long term patients. The report contains the committee's conclusions, six in number, and its five recommendations.

Copies of the report may be obtained by addressing a request to Howard A. Rusk, M.D., chairman, Health Resources Advisory Committee, Office of Defense Mobilization, Washington 25, D. C.

OBITUARIES

Joseph Arthur Girouard, M.D.

1875 - 1953



At the annual meeting of the Connecticut State Medical Society in 1950, Joseph Arthur Girouard, together with three other physicians, received a "Fifty Years in Practice" award. As he had started his practice in Willimantic in 1899, he had truly rounded the turn into and completed the span of the first half of the 20th century. When he died on September 23, 1953, he had been in active practice for four years over one-half a century, and so had been fortunate, besides having been able to live a full, useful and active life, to receive recognition in the fields of his avocations, as well as in his vocation.

Dr. Girouard's career was typical in many ways of the practice of medicine of his time. This was so both in regards to the conduct of his professional practice, his professional training, his education, and his private life. Born February 26, 1875, in Manville, Rhode Island, a son of Francois and Hermine (Cormier) Girouard, he graduated from St. Mary's College of Montreal, and then acquired a B.A. degree at Brown University. He received his professional degree upon graduating from the University of Maryland and started practice in what is now known

as the horse and buggy era. Not only was it literally the horse and buggy era, but, as he often fondly recounted, an era of the bicycle, the vehicle he used on his visits for some time. The year following the beginning of his practice in Willimantic he married Wavine Brazeau. To them were born a number of children—Gertrude Girouard and Mrs. Charles E. Martin, both of Willimantic, and a son, Dr. Fernand L. Girouard who is practicing medicine in Attleboro, Massachusetts.

Through the early years of the century Dr. Girouard's practice was quite active, especially amongst the French speaking people who made up a considerable proportion of the population in the Eastern Connecticut textile area in those days. The medical training at that time, particularly the post-graduate training of young medical practitioners, was not prolonged as is the fashion today, however, like many of the earnest hard-working practitioners of his era, Dr. Girouard continued to seek out post-graduate training under his own initiative and in 1913 spent a year in Paris. The following year he did considerable work in New York City and several years later spent an interval in Vienna, Austria. Although he continued throughout his career in general practice, he gradually did more and more general surgery. For a number of years he was on the surgical staff, a chief of a service, first at St. Joseph's Hospital, and then later at the Windham Community Memorial Hospital until his retirement.

In 1933 he was made a Fellow of the American College of Surgeons. He was also, for a long time, a Fellow of the American Medical Association, and held membership in the New England Obstetrical and Gynecological Society, the Hartford Medical Society, and the local City and County Medical Associations.

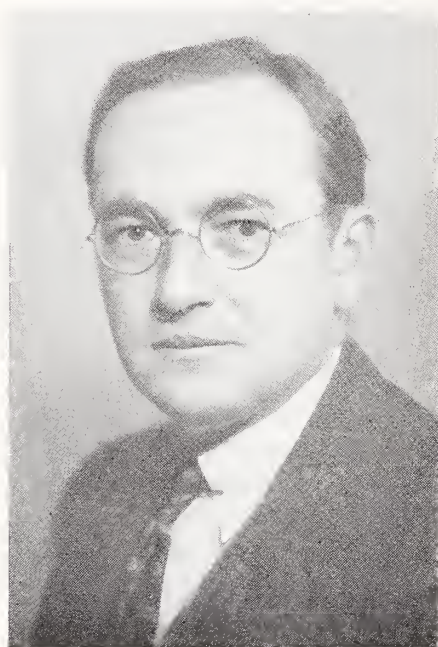
Besides his full career in medicine, he was almost as active in religious and learned groups. His endeavors in these fields were rewarded by being made an Officier d'Academie of the French Republic in 1939, and later a Knight of St. Gregory by Pope Pius XII. A Council Member of the Association of French Speaking Physicians of North America, he was also one of the founders and a leader throughout his life of St. Mary's Parish in Willimantic.

Dr. Girouard had an affable disposition and gained much pleasure in the company of his medical colleagues. For many years his vacations centered around attendance at medical conventions where his urbane manners and jovial conversation won him a surprisingly large number of acquaintances in many different parts of his own country, as well as in foreign lands.

Brae Rafferty, M.D.

J. Edward Canby, M.D.

1900 - 1955



J. Edward Canby, M.D., a leader in industrial medicine died at Hartford Hospital, on January 2, 1955.

Dr. Canby was born in New Castle, Pennsylvania, March 21, 1900, and was a graduate of Allegheny College, Meadville, Pennsylvania, in the Class of 1923. He received his medical degree from Jefferson Medical School in Philadelphia in 1927 and, following his internship, moved to Great Barrington, Massachusetts, where he practiced until 1941. In that year Dr. Canby moved to Hartford as a member of the medical staff of the Aetna Casualty and Surety Company. In November, 1942 he joined the staff of the Niles-Bement-Pond Company, where he was Medical Director of the Pratt & Whitney and Chandler-Evans Division, Niles-Bement-Pond Company in West Hartford, until his death.

Dr. Canby was an active member and leader in the New England Chapter of the Industrial Medical Association and the American Association of Industrial Physicians and Surgeons. He was a member of the Hartford County Medical Association, The Connecticut State Medical Society, and the American Medical Association. He was honored by being a delegate to the President's Conference on Industrial Safety in 1954.

Dr. Canby had great interest in civic and church affairs, and he was a devoted husband and father. He leaves his wife and two daughters and a host of friends and colleagues to whom his passing has brought the deepest grief.

John C. Leonard, M.D.

Radiation Effects on Humans

Recently before a Senate sub-committee, Dr. John C. Bugher, head of AEC's biological and medical section, said that "A . . . possible delayed effect of radiation exposure which has been demonstrated in animals is a statistical shortening of life expectancy. This phenomenon does not result from any specific cause of death but apparently from a general acceleration of the aging. Whether this factor can be recognized in a human population is as yet unknown."

The TV program "March of Medicine" on March 29 was devoted to a report on the long range effects of the atom bomb dropped on Hiroshima in 1945. The report disclosed that there have been a few cases of latent damage to survivors but no significant indications of unfavorable hereditary effects on their offspring. Hiroshima's A-bomb children are generally healthy and happy.

In the hottest Hiroshima Zone there were 185 pregnant women who survived to bear children. Only eight of these children were born with heads slightly smaller than average and they had "some degree of mental retardation." There was some temporary infertility among adult survivors. A high proportion of those in the hot area, 40 per cent, developed cataract-like spots on the eye lenses as compared with only 8 per cent in a nonexposed group. Adult survivors also developed 16 times as much leukemia as did the general population, but this meant only 44 cases.

LETTERS TO THE EDITOR

Use of "Dog Tag" Refuted

April 8, 1955

To the Editor:

This letter is written in reference to your editorial in the February issue of the CONNECTICUT STATE MEDICAL JOURNAL, p. 118, entitled "A 'Dog Tag' in Pregnancy." The type of reasoning exhibited in this editorial has been aptly characterized as "jumping from an incorrect assumption to a foregone conclusion."

The "incorrect assumption" is that a dog tag of this type would be useful. A brief analysis of some of the items which were suggested for inclusion on this tag follows.

1. THE BLOOD TEST FOR SYPHILIS

If the test should be negative early in pregnancy, this is no guarantee against the acquisition of syphilis by the time the tag has been engraved.

If the test is positive, present figures in this area indicate that there is a 50 per cent chance that this is a false positive reaction. Judgment as to the need for therapy or further diagnostic studies is the field of the family physician and not an "emergency" matter. If the woman has syphilis she needs penicillin and not a 4 plus dog tag. Some sensitive women might even object to carrying this very personal information in a place where friends might see it.

2. RH FACTOR AND BLOOD GROUP

Someone in Connecticut seems to feel that it is a great help in emergency care to have the blood group of the recipient on his auto license or somewhere about his person. No responsible physician should administer a group specific transfusion on the basis of such information. The unreliability of such "dog tags" in the military service was notorious, at least 25 per cent of the blood groups being incorrect in some outfits. Even if much greater accuracy could be achieved it is far safer to use O Rh negative blood in extreme emergencies pending typing and crossmatching at the time of the emergency.

As to care of infants carried by Rh negative mothers, the useful data are far too complex to carry on a permanent type tag. The results of the

screening test for antibodies, the periodic titres, the possibility of previous sensitization, the Rh pattern of the father are all relevant. At the time of delivery the result of the Coombs test on cord blood, the baby's bilirubin and the clinical appearance assume much greater importance than any studies of the mother's blood, which in some instances reflect reaction to previous rather than present pregnancies.

3. OTHER FACTORS

Such data as hemoglobin and presentation are sufficiently variable so that new tags would be necessary fairly often, further complicating the procedure.

All the medical and laboratory data mentioned belong in the office records of the obstetrician for proper correlation with clinical progress. They do not belong on a "dog tag" around any woman's neck as in the "foregone conclusion" of the editorial.

Incidentally a far more important opportunity for Connecticut leadership in medical care is greater support in recruiting blood donors, particularly "universal donors (Group O Rh negative)" for the Regional Blood Program.

Yours truly,
Roy N. Barnett, M.D.,
Director of Laboratories

Connecticut Medical Examining Board

March 22, 1955

To the Editor:

Your attention is directed to the enclosed copy of a memorandum of reprimand which this Board imposed upon Dr. Paul P. Duzmati, of Bridgeport, for fraudulent, dishonorable and unprofessional conduct.

You will note that part of the reprimand is a request on the part of the Board that it be published in the CONNECTICUT STATE MEDICAL JOURNAL. It is the belief of the Board that this professional publicity will have a deterrent effect on other possible derelictions of this type, and we hope that the JOURNAL will publish it.

Sincerely yours,
John D. Booth, M.D.,
President of the Board

MEMORANDUM OF REPRIMAND IN THE CASE OF
PAUL P. DUZMATI, M.D.
of 1904 Boston Avenue, Bridgeport, Connecticut
Dr. Duzmati, on February 16, 1955 you were

present at a hearing before the Connecticut Medical Examining Board at 160 St. Ronan Street, New Haven. You were there for the purpose of answering to a charge preferred against you by the State Department of Health of the State of Connecticut. The specific charge was fraudulent, dishonorable or unprofessional conduct concerning certain claims presented by you to Connecticut Medical Service, Inc. for payment covering alleged professional services rendered to (name deleted) and to (name deleted) both of Bridgeport, Connecticut. It was the contention of the State Department of Health that these claims did not accurately describe the ailments or injuries of these two patients, and that furthermore these claims were submitted for the purpose of misleading Connecticut Medical Service, Inc. into believing your professional services were compensable in the amounts claimed under the contracts issued by them to the members involved.

In the case of (name deleted), the statement of claim reads, under "Diagnosis;" "Fracture dislocation of right ankle." Further, under "What was done," you state that "after x-ray 2 per cent procaine was injected locally, the dislocation is reduced, the fragments are placed in the ideal setting and the leg is set into a plaster of Paris cast." Dr. Arthur Griswold of Bridgeport, a highly reputable and experienced orthopedic surgeon testified that he had examined (name deleted) at the request of Connecticut Medical Service and that he had taken a careful history and had reviewed the x-ray films taken in your office and also subsequent films taken in the office of Dr. Harold Lockhart, radiologist, of Bridgeport. He concluded that the extent of this patient's injury was a chip fracture of the posterior aspect of the astragalus. Since the patient walked to your office with the help of a cane only, Dr. Griswold seriously doubted that there ever was a dislocation. And finally, since the support which you applied was worn inside the patient's shoe, he questioned whether a plaster of Paris cast had been applied. On your claim form you suggested Connecticut Medical Service payment was \$100. It seems hardly necessary to refer to your letter of April 27, 1954 to Connecticut Medical Service in which you describe in even greater detail multiple fractures of the bones of the ankle.

In the case of (name deleted) you followed a similar pattern in your statement of claim, describing fractures of both femurs, fracture of the fibula, shaft and maleolus, and under "Operation": "Fracture of

femur—closed." Dr. Robert G. Reynolds, an experienced orthopedic surgeon of Hartford and a member of the Professional Policy Committee of Connecticut Medical Service, testified that he had reviewed your films of the (name deleted) boy and could find only a fracture of the shaft of the fibula. In this case your suggested Connecticut Medical Service payment was \$100.

Having heard this testimony and listened to arguments both by the Assistant Attorney General, Mr. Weinstein, and your counsel, Mr. Samuel Reich, it is the opinion of this Board that you are guilty of fraudulent, dishonorable or unprofessional conduct in both the case of (name deleted) and that of (name deleted) as set forth in the detailed charge of the Department of Health of the State of Connecticut.

Having found you guilty, this Board has three alternatives, revocation of your license, suspension of your license, and reprimand. The Board does not believe that your conduct was reprehensible enough to warrant revocation or suspension of your license and has therefore decided on this reprimand, which will be filed with the State Department of Health and the Attorney General as a public document and submitted to the CONNECTICUT STATE MEDICAL JOURNAL with a request that it be published.

It is our firm belief that ever since its inception, Connecticut Medical Service has been of inestimable benefit to its thousands of subscribers. Its remarkable growth and success has been due in large part to the faith which Connecticut Medical Service has placed, not only in its members but in the doctors. We believe you have broken that faith and such conduct cannot be condoned since we are of the conviction that a physician must not only be skilled in the art of medicine but he must be honest and forthright in his dealings with others.

We are hopeful that this unpleasant experience before this Board will act as a deterrent in the future, for surely if there should be a repetition and it is brought to our attention you will receive no such consideration as you have in this instance.

(Signed)

John D. Booth, M.D.,
President of the Board

Louis P. Hastings, M.D.,
Carl E. Johnson, M.D.,
John H. Bumstead, M.D.,
C. Louis Fincke, M.D.

Deaf Instructors Convention

March 30, 1955

To the Editor:

Dr. Norton Canfield has suggested that I send you an announcement on the thirty-seventh biennial Convention of the American Instructors of the Deaf which will be held at this School from June 26 to July 1, 1955.

This Convention is the major professional group in this field and will probably attract an attendance of some 1,000 delegates. A very interesting program is being arranged, including demonstrations and technical aspects of the education of the deaf, as well as a number of outstanding speakers on more general subjects.

There will be one panel discussion dealing with the medical aspects of deafness. Dr. Norton Canfield is chairman of the panel, and he will have with him Dr. Edward H. Truex, Jr., and a speech specialist. This is scheduled for Thursday, June 30, from 3:00 to 3:50 P. M.

We would be happy to have any members of the Connecticut Medical Society attend any meetings which they may find of interest. A copy of the program will be available in a few weeks.

With all good wishes, I am

Sincerely,
E. B. Boatner,
Superintendent

OUR NEIGHBORS

Massachusetts

Sidney Burwell, research professor of clinical medicine at Harvard Medical School since 1935 and formerly dean of the Medical School, will become the first Samuel A. Levine professor of medicine. This new chair was established six months ago by Charles E. Merrill, a New York investment banker, in honor of his friend and physician who was clinical professor of medicine at Harvard and a prominent cardiologist in this country.

New Hampshire

The New Hampshire Medical Society, in a study of free medical care, conducted a survey among general practitioners and specialists. This showed

that somebody, somewhere in New Hampshire gets \$4 worth of free medical care and treatment every minute.

The society places the annual value of this free medical care at \$2,096,640. Or, to put it another way, the value of this free medical care is \$40,320 per week or \$5,760 every day.

In a news release about its study, the society said that "just about every practicing physician does some charity work. The scope of this depends upon the doctor's geographical location, the economic status of patients in his area, and the type of professional service rendered."

On the basis of its present active membership, the New Hampshire Medical Society credits the average doctor in the State with providing \$3,425 worth of free medical care a year—slightly more than \$65 weekly. That's the average.

For surgeons and specialists the free care—measured in terms of dollars and cents—would be substantially greater. Free surgery—that is, surgery for which the physician-surgeon receives no payment or performs the work at a reduced rate—may amount to \$1,000 or more a month, the society study showed.

Vermont

The Vermont Legislature will act this session on two bills, one requesting a bond issue of \$250,000 to set up a rehabilitation center, the other to create a Commission on Aging which will "plan, initiate and promote programs, practices and projects relating to the problems of aging persons and coordinate the same with individuals, groups, agencies, associations and organizations concerned therewith." The two bills are the first to follow the report of a commission appointed in Vermont to study the problems of chronic illness of the aging.

Funds Approved for Fallout Curbs

The House of Representatives has voted for an early start on measures to protect the nation against radioactive fallout. It gave Governor Val Peterson, Federal Civil Defense Administration, broad authority to spend up to \$30 million to buy and distribute instruments for detecting fallout and to train Civil Defense leaders in their use. The new authority was in an amendment, adopted by Voice Vote, to a \$5,856,000,000 independent offices appropriations bill.

SPECIAL NOTICES

AMA ANNUAL MEETING

Atlantic City, June 6-10, 1955

Hotel reservations should be made through AMA Housing Bureau, Atlantic City, New Jersey.

AMA MEDICAL CIVIL DEFENSE CONFERENCE

The Council on National Defense of the American Medical Association is conducting its third Annual Medical Civil Defense Conference on Saturday, June 4, 1955 in Atlantic City, New Jersey.

AMA: ATLANTIC CITY: JUNE 6-10, 1955

AMA has lined up nearly five full days of lectures, scientific and technical exhibits and color television and motion picture presentations to give you a good "short course" in postgraduate medical education. Between 13,000 and 16,000 physicians are expected to attend the convention which will center its activities in the Atlantic City Auditorium and adjacent hotels. Headquarters will be at the Traymore hotel where the House of Delegates will convene.

Outstanding scientific features include: A report on the Salk polio vaccine trials at a joint meeting of the sections on pediatrics and preventive medicine; a general discussion of resuscitation of the newborn for the sections on anesthesiology, diseases of the chest, general practice, obstetrics and pediatrics; exhibit-symposiums on rheumatism and diabetes; fracture and fresh pathology exhibits, and a new "Queries and Minor Notes" feature in which consultants from all branches of medicine will be on hand in convention hall to answer physicians' questions concerning specific cases. In addition, the Air Force will demonstrate its "flying infirmary" on the beach in front of the Auditorium throughout the week.

More than 325 scientific exhibits and 350 technical exhibits will be on display. The color television program will present interesting surgical and clinical demonstrations piped directly into the Auditorium from Philadelphia hospitals.

Special note to all physicians: The auditorium will be open exclusively for physicians from 8:30 A. M. to 12 noon on Wednesday so that you may move more freely among the exhibits and have more time for questioning exhibitors.

Plan now to attend this worthwhile medical meeting. Watch the *Journal of the A. M. A.* for further details.

AMERICAN HEART ASSOCIATION

The 1955 Annual Meeting and Scientific Sessions will be held at the Jung Hotel, New Orleans, October 22-27, 1955.

Scientific sessions are tentatively scheduled to be held

on the first three days, Saturday, October 22 through Monday, October 24. The Annual Meeting of the Assembly is planned for Tuesday and Wednesday, October 25 and 26, while the Staff Conference of Heart Associations is scheduled to hold its sessions Wednesday, October 26.

AMERICAN MEDICAL ASSOCIATION CLINICAL SESSION — 1955

Save these dates now

November 29, 30, December 1, 2, 1955

Mechanics Hall, Boston, Massachusetts

ABSTRACTS

(1) Abstracts of papers to be offered for presentation at the Clinical Session of the American Medical Association must be submitted in duplicate before July 15, 1955, with an absolute deadline of August 1, 1955. They should be sent to Chairman of the Program Committee, AMA Clinical Session, 22 Fenway, Boston 15, Massachusetts.

(2) Titles of papers alone will not be considered by the Program Committee, and abstracts of subjects for presentation must be presented as described below.

(3) Abstracts must be limited to a 300 word summary including important data and conclusions. Charts and tables may be attached to aid in the selection of papers.

(4) All abstracts and papers will be reviewed by the Program Committee and, when necessary, by experts in special fields in order to select those containing the most suitable material. Final selection will be on a competitive basis.

(5) Subjects for presentation at the meetings may include clinical and scientific aspects of all branches of medicine and surgery, as well as the results of investigative work bearing on these subjects.

(6) The names, titles, including hospital affiliations, and complete addresses of all authors must accompany each abstract. The author who is to present the paper must be the first author listed in the abstract.

(7) Those wishing to present subjects of a confidential nature from the armed forces or other sources must clear the material through official channels before submitting the abstracts to the Chairman of the Program Committee.

(8) It is urged that all who desire a place on the program of the Clinical Session submit their abstracts as early as possible in order to facilitate the work of the Program Committee in competitive selection of papers. The deadline, however, must be met in order to get the program ready. Remember the deadline is July 15, 1955.

PAPERS

(1) Subsequent to review of the abstracts by the Program Committee, papers will be selected on a strictly competitive

basis from among the abstracts for presentation at the Clinical Session. Authors will be notified by September 15, 1955, whether or not their papers are accepted for presentation.

(2) Papers presented at the Clinical Session must be original contributions which have not been previously presented or published. All such papers should be considered as belonging exclusively to the American Medical Association and should not be submitted for publication elsewhere without the advance permission of the American Medical Association.

(3) The time allotted for presentation of papers at the Clinical Session in November will be strictly limited by the committee to twenty minutes, including lantern slides, in order to permit five minutes of discussion following the paper.

Frank P. Foster, M.D., General Chairman; Theodore L. Badger, M.D., Chairman Program Committee.

Foreign Medical Meetings

JULY

- 18-23—London
12th Congress of the International Association of Psychotechnology
C. B. Frisby, National Institute of Industrial Psychology, 14, Welbeck Street, London, W.1
- 24-31—Copenhagen
16th Congress of the International Society of Surgery
Dr. Hasner, 7, Blegdamsvej, Copenhagen
- 25-30—Paris
International Federative Congress of Anatomy
Secretary General, Prof. G. Cordier, 3, square Alboni, Paris 16, France
- 27-30—Oxford, England
14th British Congress of Obstetrics and Gynaecology
The Secretary, 14th British Congress of Obst. & Gyn., Maternity Dept., Radcliffe Infirmary, Oxford
- Dublin
Irish Medical Association
The Irish Medical Association, 10 Fitzwilliam Place, Dublin, Ireland

AUGUST

- 1-5—Stockholm and Upsala
International Congress of Plastic Surgery
Dr. Tord Skoog, Upsala University, Sweden
- 1-6—Brussels
International Union of Biochemistry—3rd International Congress
Prof. C. Liébecq, 17, Place Delcœur, Liège
- 5-10—Munich
Eighth International Conference of Social Work in Germany
International Conference of Social Work, 345 East 46th Street, New York 17, N. Y., U. S. A.
- 15-20—Copenhagen
International Dental Federation—Annual Reunion
Mr. G. H. Leatherman, 35, Devonshire Place, London, W.1

- 17-24—Melbourne
Australian and New Zealand Association for the Advancement of Science
Prof. J. R. A. McMillan, 157, Gloucester Street, Sydney, N.S.W.
- 19-27—Sydney
Australasian Medical Congress (B.M.A.)—9th Session
Dr. J. G. Hunter, B.M.A. House, Macquarie Street, Sydney
- 20-27—Sydney
Australasian Medical Congress (British Medical Association)
Federal Council of the British Medical Association in Australia, 135 Macquarie Street, Sydney, N.S.W.
- 27-30—Bornholm
Annual General Meeting and Annual Representative Meeting—Danish Medical Association
Dr. V. A. Fenger, Danish Medical Association, Kristianiagade 12 B, Copenhagen 0, Denmark

SEPTEMBER

- 2-4—Evian, France
4th International Medical Congress
Dr. P. Laouenan, Etablissement Thermal, Evian
- 5-10—Scheveningen, Netherlands
World Congress of Anaesthesiology
W. A. Fentener van Vlissingen, Noord-Houdringelaan, 24, Bilthoven
- 11-18—London
3rd International Congress of Criminology
The Organising Secretary, 28, Weymouth Street, London, W.1
- 12-17—London
2nd International Congress of Neuropathology
Dr. W. H. McMenemy, Maida Vale Hospital, London, W.9
- 13-17—London
4th Symposium Neuroradiologicum
Dr. R. D. Hoare, National Hospital, Queen Square, London, W.C.1
- 19-22—London
National Pharmacy Exhibition
British and Colonial Druggist Ltd., 194-200, Bishopsgate, London, E.C.2
- 19-23—London
16th General Assembly of the International Pharmaceutical Federation
Mr. D. F. Lewis, Pharmaceutical Society of Great Britain, 17, Bloomsbury Square, London, W.C.1
- 19-24—Baden-Baden
Arbeitsgemeinschaft der Westdeutschen Arztekammern—57. Deutscher Arzttag
Prasidium des Deutschen Arzttages, Auslandsdienst, Stuttgart-Degerloch, Jahnstr. 32
- 20-26—Vienna, Austria
9th General Assembly of The World Medical Association
Secretary General, Dr. Louis H. Bauer, 345 East 46th Street, New York 17, New York, U.S.A.
- Imbabura—Ibarra, Ecuador
VI Asamblea Médica Federal Nacional
Dr. José David Paltan, Federación Médica del Ecuador, Casilla #2269, Quito, Ecuador

OCTOBER

6-8—Liverpool

British Orthopaedic Association—Annual Meeting

The Association, 45, Lincoln's Inn Fields, London, W.C.2

17-20—San Francisco

American Dental Association—96th Annual Meeting

American Dental Association, 222 East Superior Street, Chicago 11, Illinois

17-22—Pretoria

40th South African Medical Congress

Dr. D. A. Fowler, Room 28, Administrative Building, General Hospital, Pretoria

24-27—Washington, D. C.

International Anaesthesia Research Society Congress

Dr. William Friend, 515 Nome Avenue, Akron 20, Ohio

NOVEMBER

6-12—Rio de Janeiro

2nd International Congress of Allergology

Dr. Roberto J. Taves, Avenue Rio Branco 277, 9° andar, grupo 904, Rio de Janeiro

29-Dec. 2—Boston

American Medical Association—1955 Clinical Meeting

Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Illinois

AMES AWARDS CONTEST OF THE AMERICAN COLLEGE OF GASTROENTEROLOGY

The American College of Gastroenterology, in cooperation with the Ames Company of Elkhart, Indiana, takes pleasure in announcing the establishment of the Ames Award Contest for the best papers in Gastroenterology.

There will be classes of awards as follows:

FELLOWS OR RESIDENTS OF GASTROENTEROLOGY

First Prize—\$250, a certificate of merit and a 1 year subscription to *The American Journal of Gastroenterology*, official publication of the American College of Gastroenterology.

Second Prize—\$50, a certificate of merit and a 1 year subscription to *The American Journal of Gastroenterology*.

FIRST OR SECOND YEAR INTERNES

First Prize—\$250, a certificate of merit and a 1 year subscription to *The American Journal of Gastroenterology*, official publication of the American College of Gastroenterology.

Second Prize—\$50, a certificate of merit and a 1 year subscription to *The American Journal of Gastroenterology*.

BEST PAPER PUBLISHED

For the best paper published in *The American Journal of Gastroenterology*, during the twelve months ending June 30, 1955, for which no prize has been previously awarded, \$100.

RULES AND REGULATIONS

All papers submitted must represent original work in Gastroenterology, must not have been previously published except for abstracts or short preliminary reports and must not have been previously presented at any National meetings.

The contents of the papers can be clinical or basic science. Clinical papers must not be case records, but controlled clinical work.

The length of a paper is no criterion for originality or value.

All entries for the 1955 prizes, with the exception of those already published in *The American Journal of Gastroenterology*, must be typewritten in English, double-spaced on one side of the paper and submitted in six copies.

The winning entries will be selected by the Research Committee of the American College of Gastroenterology and the awards will be made at the Annual Convention Banquet of the College, to be held in Chicago, in October, 1955.

All papers selected for awards become the property of the American College of Gastroenterology and the decision of the judges will be final. Should none of the papers submitted meet the standards set by the Committee, the Committee reserves the right to withhold the making of any award.

The recipients of the first prizes will present their paper in person at the Annual Meeting of the College.

All unpublished entries must be received no later than September 1, 1955 and should be addressed to the Research Committee, American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

MOTION PICTURE FILMS

A completely revised Fourth Edition of "Professional Films" is now in compilation. (The frequency and number of future insert pages necessary to assure a comprehensive index that is continuously current over a period of years will be determined by the volume of forthcoming productions.) It will include new sections providing biographical data on authors, and information on the audio-visual activities of medical schools, dental schools and postgraduate teaching centers.

Over 28,000 copies of previous Editions are in use by medical and dental schools, Program Chairman of State and specialty societies, and others here and abroad. AIM provides this valuable audio-visual information to the profession-at-large, without profit, as one of its contributions towards elevating the standards of medical and dental services by expediting the dissemination of professional knowledge.

You are urged to directly assist by (1) informing film authors of this announcement so that they can write for questionnaires, or (2) providing the film title and full name and address of any film author. Write to the Academy-International of Medicine, 601 Louisiana Street, Lawrence, Kansas.

OUT-PATIENT CLINIC FACILITIES FOR HARTFORD

Hartford Hospital

80 Seymour Street—Tel. JA 4-5911

Numerals designate the following:

1. Type of Service.
2. Schedule.
3. Eligibility.
4. Costs or fees.

A. DIAGNOSTIC CLINIC

1. Full diagnostic studies with referral to the private physician for treatment.
2. A. New Service Patients
Monday through Friday, 1:00-4:30 P. M.
- B. New Semi-Private Patients
Monday through Friday, 9:30-1:00 P. M.
- C. Follow-up Patients
Monday through Saturday, 8:30-12:00 NOON
3. A. Semi-Private: Income between \$3,500-\$6,000, eligibility depending on social service evaluation, especially number of dependents.
- B. Ward Level: Income below \$3,500.
4. Costs average about \$60 plus laboratory fees at ward rates.

B. MEDICAL CLINIC AND MEDICAL SPECIALTY CLINICS

1. Follow-up of previously hospitalized cases, referrals from Diagnostic Clinic.
2. A. Allergy Thursday, 10:00-12:00 NOON
- B. Arthritis Thursday, 9:00 A. M.
- C. Cardiac Thursday, 10:00-12:00 NOON
- D. Chest Wednesday, 11:00-12:00 NOON
- E. Diabetes Wednesday, 9:00-12:00 NOON
- F. Endocrine Friday, 10:00 A. M.
- G. Gastroenterology Monday, 10:00-12:00 NOON
- H. Hematology Tuesday and Thursday, 1:30 P. M.
- I. General Medical
Monday through Saturday, 8:30-12:00 NOON
3. Same as 3. A, B, above.
4. Fee \$2 per clinic visit.

C. SURGICAL AND PEDIATRIC FOLLOW-UP CLINIC

1. Follow-up of previously hospitalized cases—or cases from Diagnostic Clinic.
2. A. Gynecology 1st and 3rd Tuesday, 9:30-12:00 NOON
- B. Neurology Monday, 1:30-4:30 P. M.
- C. Neurosurgical Thursday, 1:30-4:30 P. M.
- D. Pediatric Wednesday, 1:30-3:30 P. M.
(except 4th Wednesday)
- E. Surgical follow-up 4th Wednesday, 1:30-4:30 P. M.
3. Eligibility determined by social service interview.
4. Fee: \$2 per clinic visit.

D. PRENATAL CLINIC

1. Prenatal, delivery and postnatal care.
2. 8:30-3:00 P. M. For appointments call JA 4-5911, Ext. 434.

3. All patients desiring Ward service obstetrics are eligible.
4. Registration fee \$10. Fee for complete prenatal, delivery and postnatal care, \$160. Slightly higher if complicated delivery.

E. MENTAL HYGIENE CLINIC

1. Patients with recent mental symptoms, desiring help. Follow-up on Hartford Hospital admissions and Norwich State Hospital.
2. Hours by appointment.
3. Physicians referral of self referral. Social service interview to determine eligibility.
4. Fee: \$1-\$5 per visit.

F. POLIOMYELITIS CLINIC

(Administered by National Foundation for Infantile Paralysis.)

1. Convalescent treatment and rehabilitation for poliomyelitis patients.
2. First Tuesday of Month, 8:30 A. M.
3. Any patient having had polionmyelitis eligible.
4. No Fee.

G. TUMOR CLINIC

1. Referral for initial diagnostic visit and follow-up of previously hospitalized cases or cases from the Diagnostic Clinic.
2. ENT, Medical, Radiology Friday (1st) 9:30-12:00 NOON
Genito-Urinary, Surgical Friday (2nd) 9:30-12:00 NOON
Breast Friday (3rd) 9:30-12:00 NOON
Gastro-Intestinal Friday (4th) 9:30-12:00 NOON
Radiological Friday (3rd) 9:30-12:00 NOON
3. Eligibility. Anyone may be referred for the initial diagnostic visit; follow-up as for wards.
4. Fee: No charge for visit; x-rays, and laboratory fee only.

St. Francis Hospital

114 Woodland Street—Tel. CH 9-8281, Ext. 411 & 414

A. OUT-PATIENT CLINIC

1. & 2.

A. Allergy	Monday and Friday, 8:00 A. M.
B. Cardiac	Wednesday, 9:00 A. M.
C. Chest	Wednesday, 9:00 A. M.
D. Gynecology	Thursday, 9:00 A. M.
E. Luetic	Tuesday, 11:00 A. M.
F. Medical	Tuesday, 9:00 A. M.
G. Orthopedic	Saturday, 9:00 A. M.
H. Pediatric	Wednesday, 9:00 A. M.
I. Rheumatic Fever	Wednesday, 9:00 A. M.
J. Seizure	Saturday, 9:00 A. M.
K. Surgical	Monday and Thursday, 1:00 P. M.
L. Tumor	Thursday, 10:00 A. M.
3. Referral by physicians and agencies. Appointments through Social Service Department. Eligibility determined by interview with Social Service Department.
4. Clinic visit fee—50¢. Extra charges for special services (e.g. x-ray, lab. tests, treatments, etc.) at clinic rates.

B. 1. MATERNITY CLINIC

2. Registration Wednesday, 1:00 P. M.
Prenatal Tuesday and Friday, 1:00 P. M.
Post Partum Friday, 1:00 P. M.
Baby Clinic Thursday, 9:00 A. M.
3. Referral by physician and agencies.. Appointments through Social Service Department. Eligibility determined by interview with Social Service Department.
4. Maximum charge for maternity clinic including all hospital costs—\$135.

C. MISC. OUT-PATIENT SERVICE

Physicians may send private patients by appointment for treatments requiring the use of special hospital equipment. These services may include intravenous therapy, blood transfusions, etc.

Mount Sinai Hospital

500 Blue Hills Avenue—Tel. JA 2-7261

A. PRENATAL CLINIC

1. Prenatal care, delivery and post partum follow-up
2. Clinic hours Friday, 8:30-10:30 A. M.
For appointments call JA 2-7261 Ext. 253.
3. Patients requiring Ward Service, Social Service interview and Casework service available.
4. Fee: Ward rates for complete Obstetrical Service

B. TUMOR CLINIC

1. Follow-up of previously hospitalized case. Diagnostic examinations for tumors or suspicious growths.
2. Clinic hours
(2nd) Thursday of each month 11:00-12:00 NOON
Appointments arranged by staff physicians, social agencies or the Connecticut Cancer Society in Hartford.
3. Patients requiring Clinical Service
4. No Fee

C. PERIODONTAL CLINIC

1. Treatment of periodontal disease (pyorrhea), Vincent's infection and other oral diseases. Treatment includes: Scaling, Subgingival curettage, Gingivectomy, Occlusal Adjustment, Temporary Splinting, Instruction in home care regimen.
2. Clinic hours Tuesday, Wednesday, Friday
9:00-12:00 NOON
by appointment
call daily JA 2-7261 Ext 253
3. Dentists, Social and Health Agencies, self referral.
Social Service interview to determine eligibility.
4. Fee: \$5 for Laboratory Tests, X-rays, and Examination.
\$2-\$3 per Clinic visit.

McCook Memorial Hospital

2 Holcomb Street—Tel. JA 7-3251

A. GENERAL CLINIC

1. Patients of all types are seen in General Clinic (exceptions listed below under special clinics).
2. Monday, Wednesday and Friday 8:30 A. M.

3. In general, patients eligible for Welfare Aid from the Hartford Welfare Department are eligible for clinic care. They may be on general family aid, or merely medical aid. Eligibility is determined by the Hartford Welfare Department using the Family Budget figures of the Greater Hartford Community Council.
4. There is no charge to welfare recipients. For State Aid and the private patient \$3.50 per visit.

B. 1. SPECIAL CLINICS

2. Clinic hours in general are 8:30 A. M.

The day schedule for the special clinics is as follows:

- | | |
|---|---|
| A. Allergy | Friday |
| B. Cancer detection | Tuesday |
| (appointment through Conn. Cancer Society) | |
| C. Dental Clinic | Monday, Wednesday, Friday
by appointment |
| D. Diabetes | Every second week, Friday |
| E. Ear, Nose and Throat | Friday |
| (Children for tonsil and adenoid operation may be referred directly to the clinic.) | |
| F. Eye | Monday |
| (Children of school age may be referred directly, others referred from general clinic.) | |
| G. Genito-urinary | Wednesday |
| H. Gynecology | Thursday |
| I. Medical follow-up | Wednesday |
| J. Orthopedic | Friday |
| K. Pre and post natal | Thursday |
| (Prenatal referral not necessary from general clinic—bring urine specimen.) | |
| L. Skin | Tuesday |
| M. Surgical | Thursday |
| N. Tumor | Every third Saturday in the month |
| O. Miscellaneous | By appointment |
| (Pediatric and neurosurgical, appointment through social service.) | |

3. Unless otherwise specified, all patients must be referred from the general clinic for specialized clinics.
4. See General Clinic 3 and 4.

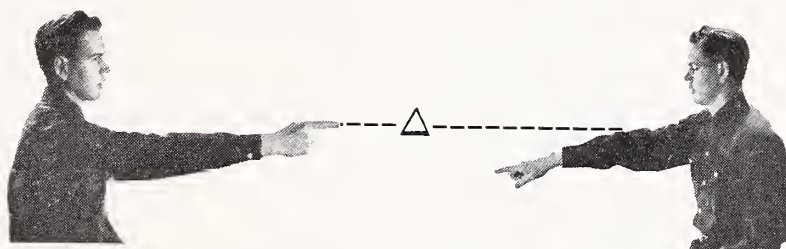
Hartford Dispensary

56 Winthrop Street—Tel. JA 5-2181

A. GENERAL AND SPECIAL CLINICS

- | | |
|--|------------------------------|
| 1. A. Alergy | Monday |
| B. Arthritis | Friday |
| C. Cardiovascular | Friday |
| D. Chiropody | 2nd and 4th Wednesday |
| E. Dental | Daily |
| F. Dental-extractions | Wednesday through Friday |
| (Emergencies daily when dentist is in clinic—some P.M. clinics.) | |
| G. Dental fillings | Daily |
| H. Dental Prophylaxis | Daily—P. M. |
| I. Dermatological Clinic | Wednesday and Thursday |
| J. Diabetes | Every other Friday |
| K. Ear, Nose and Throat | 2nd Monday and 4th Wednesday |

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Notes on the Diagnosis and Management of "Dizziness"

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1. Swartout, R., III, and Gunther, K.: "Dizziness;" Vertigo and Syncope, GP 8:35 (Nov.) 1953.

2. DeWeese, D.D.: Symposium: Medical Management of Dizziness: The Importance of Accurate Diagnosis, Tr. Am. Acad. Ophth. 58:694 (Sept.-Oct.) 1954.

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(To be continued)

NEWS

from County Associations

Fairfield

Nathaniel Selleck, Danbury, was elected and installed as president of the Fairfield County Medical Association at its 163rd annual meeting on April 4 at the Stratfield Hotel, succeeding Russell A. Keddy, Stamford. Other officers elected were J. Donald Corridon, South Norwalk, vice-president; Michael A. Dean, Bridgeport, secretary and Joseph C. Qua-

trano, Bridgeport, treasurer. Edwin R. Connors is the retiring secretary, having served six years in that post.

Drs. Connors and Keddy were presented with gifts by the Association for their services.

Delegates to the House of Delegates elected were: Meyer Abrahams, New Canaan; Joseph L. Carwin, Stamford; George R. Cody, Norwalk; Edwin R. Connors, Bridgeport; Nathan H. Friedman, Stratford; John G. Frothingham, New Canaan; James D. Gold, Bridgeport; D. Olan Meeker, Riverside; Bernard O. Nemoitin, Stamford; William M. Stahl, Jr., Danbury; Jacques Van B. Vorhis, Darien.

Alternate delegates elected were: Robinson H. Dorion, Stamford; Maxon H. Eddy, Bridgeport; Charles B. Gaffney, Bridgeport; Walter I. Gryce, Danbury; Martling B. Jones, South Norwalk; Harry S. Phillips, Westport; James F. Rogers, Stamford; Ignatius J. Vetter, South Norwalk.

Nominations for the CMS Professional Policy Committee were Eric Norrington, obstetrics and gynecology and Cotton Rawls, surgery.

The speaker at the dinner following the business session was Phillip D. Stern, Bridgeport, on "Man and the Universe."

David B. Smith, investment banker, was the speaker at the April meeting of the Bridgeport Medical Society held at St. Vincent's Hospital. His subject was "Investments for the Physician."

Alfred Joseph Sette, secretary of the surgical staff and director of clinics at Stamford Hospital, died there suddenly on March 12. Dr. Sette was a past president and secretary of the Stamford Medical Society and a former member of the Italian Institute.

Hartford

Mr. C. Manton Eddy, vice-president and secretary of the Connecticut General Life Insurance Company, was guest speaker at the 163rd annual meeting of the Hartford County Medical Association last month.

Mr. Eddy discussed President Eisenhower's Re-insurance Program. He served in the original group of insurance advisors to Mrs. Oveta Culp Hobby's Department of Health, Welfare and Education in 1954 when reinsurance was first proposed.

He has been on several occasions an advisor to state and federal government departments on insurance matters. More recently he has been a member

of the Commission on the Financing of Hospital Care, an insurance consultant to the Medical Services Task Force of the Hoover Commission and a member of the Connecticut Commission to Study the Problems of the Aging.

He first joined Connecticut General in its actuarial department in 1922, the year of his graduation from Brown University. Since 1926 he has been a Fellow of the Actuarial Society of America. He has also been responsible for the Company's group insurance and group pension and sales activities since 1937.

Last month Dr. Mildred H. January, medical director of the New Britain Mental Hygiene Clinic, participated in the 32nd annual meeting of the American Orthopsychiatric Association in Chicago.

Charles E. Jacobson, Jr. has now opened a second office in Manchester for the practice of urology. Dr. Jacobson also has an office in Hartford. He is chief of urology at the Manchester Memorial Hospital.

Anesthesiologists Ralph M. Tovell and Charles M. Barbour, Jr. recently flew to Washington to attend a meeting of the subcommittee on anesthesia

of the National Research Council. Dr. Barbour was a speaker.

Samuel Donner was reelected president of the medical staff of McCook Memorial Hospital this past month. Claude C. Kelly and D. Dillon Reidy were reelected vice president and secretary respectively at the same hospital. Elections to the consulting staff were: Carl L. Thenebe, epidemiologist; Glover E. Howe, gynecologist; J. Gerald Olmstead, pediatrician; Manuel Hirschberg, pediatrician; and Maurice Pike, orthopedist. Loftus Walton was promoted to attending gynecologist; Henry Glaubman, attending pediatrician; John E. Cartland, associate pediatrician; and Edmund Beizer, associate surgeon.

A recent study made by the Bureau of Medical Economic Research of the AMA on hours worked by physicians corroborates a study made by Hartford County Medical Association last summer on its members working time. The national study which surveyed 30,000 physicians found that general practitioners worked more than 60 hours a week and some specialists 50 to 56 hours, and that all physicians averaged more than 56 hours per week. The Hartford County Medical Association study indicated that general practitioners in Hartford County

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worked longer—64 hours per week to be exact. Specialists worked anywhere from 49½ hours to 56¼ hours, and all physicians averaged 55 hours per week.

I. S. Geetter, M.D., administrator, Mount Sinai Hospital, Hartford, was elected to the Board of Trustees of the New England Hospital Assembly at its Annual Meeting in March in Boston. Dr. Geetter, a past president of The Connecticut Hospital Association, is presently chairman of its Council on Nursing Relations, and a member of its Committees on Blood Banking and Psychiatric Care in General Hospitals, its Council on Professional Relations and the Connecticut Joint Commission for Improvement of Care of the Patient.

The new officers of the Hartford County Medical Association are Thomas M. Feeney, Hartford, president; Harold M. Clarke, New Britain, vice president and alternate councilor; Philip M. Cornwell, Hartford, secretary; John N. Gallivan, East Hartford, councilor.

Lawrence H. Frost, a practicing physician in Plainville for over 40 years, was tendered a testimonial dinner recently by the local Chamber of Commerce.

James F. Rooney of Plainville, formerly a urologist on the staff of St. Francis Hospital, Hartford, died in that hospital on March 28. Dr. Rooney served for 41 years as a school physician for the Hartford Board of Health.

Charles Weer Goff of Hartford was the recipient of an award consisting of an embossed certificate and \$1,000 for further research presented by Kappa Delta, a national women's fraternity, at the annual meeting of the American Academy of Orthopedic Surgeons in Los Angeles in February. The subject of Dr. Goff's research is osteochondroses, a disorder of growth centers of bones in children and youths, and is published in book form, entitled "Legg-Calve-Perthes Syndrome and Related Osteochondroses of Youth" (Charles C. Thomas, Springfield, Illinois).

The research analyzed all the growth disorders affecting growing centers of bone, resulting in an avascular necrosis or a devitalization of bone, complete or partial. A new classification was presented, based upon fresh correlations as related to extensive investigative procedures such as anthropometric determinations, x-ray studies related to bone age and stages of the disorders, genetics, racial differences, anatomic differences and a deceleration of growth

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in general. An extensive historical dissertation was given, incidentally pointing out that the first paper was reported at a meeting of orthopedists in Hartford in 1910 by a Boston surgeon. A foreword was written by the last of the great pioneers, a French surgeon named Calvé, who died last year. Special treatment was outlined for these disorders, including the stimulation of growth in general, produced by the new antibiotics. This was suggested by similar effects accomplished in chickens and cattle raised for food consumption.

Five such awards previously have been made. This is the first time the award has been given for research done in Connecticut.

Middlesex

A. W. Thomson and W. J. Sweeney have been teaching in the Prenatal Clinic at Cornell Medical College.

New Haven

The Fifth Annual Cardiac Grand Rounds were held at St. Mary's Hospital, Waterbury, on April 7. The attendance was both local and statewide. Charles E. Kossman, associate professor of medicine

at New York University Post Graduate Medical School, spoke on "Myocarditis," Charles A. R. Connor, assistant professor of clinical medicine at the same school, spoke on "Heart Disease of Unknown Etiology;" and Gene H. Stollerman, instructor in medicine at New York University College of Medicine, discussed "Prophylaxis of Rheumatic Fever." The program was under the joint sponsorship of the Waterbury Area Heart Association, Inc. and the Professional Educational Department of St. Mary's Hospital.

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John F. Fulton, physiologist and Sterling professor of the history of medicine at Yale University, delivered the first Louis H. Bauer lecture at the 26th annual meeting of the Aero Medical Association in Washington in March. This lecture was established in honor of the Association's founder and first commandant of the U. S. Air Service School of Aviation Medicine from 1919 to 1925.

New London

The annual meeting of the New London County Medical Association was held at the Seaside State Sanitarium, Waterford, Connecticut, on April 7. The meeting was presided over by President John Suplicki of Norwich. Dr. Marvin, president of the Connecticut State Medical Society extended the greetings of the State Society. Dr. Couch of Cromwell also spoke briefly, as did Dr. Osborn, the State health commissioner, who spoke on the new polio vaccine program. The following new members were elected to membership: Walter M. Brown of Groton, Harvey Mandell of Norwich, Elemens E. Prokesch of New London, Elsie Tytla of New London, Franklyn Ward of Norwich. Officers

elected for the coming year are as follows: President, Eric Blank of New London, Vice President, Lewis Sears of Norwich; Secretary-Treasurer, William J. Murray, Jr. of New London; Councilor, Henry Archambault of Taftville; Alternate Councilor, Richard Starr of New London. Frederick Hartman and David Rousseau were elected new members of the Board of Trustees. State delegates are Peter Schwarz of Norwich, Morris Sulman of New London, Edmund Douglass of Groton, William Murray of New London, Sidney Drobnes of Norwich, and

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Harold von Glahn of Old Lyme as first alternate, Winfield Kelley of Norwich as second alternate. John Suplicki was named to the State Committee on Professional Relations and Edmund Douglass was named to the Committee on State Legislation. Harold Irwin and Harold Higgins were nominated to the Professional Policy Committee of CMS. At the scientific session, George Mitchell, professor of gynecology and obstetrics at Tufts Medical College, talked on "Cancer of the Female Genital System."

The monthly dinner lecture of the Lawrence Memorial Associated Hospital was held March 17. The speaker was Dr. Swensen, professor of pediatrics surgery at Tufts Medical college and chief of surgery at the Boston Floating Hospital, and his subject was "Problems in Pediatric Surgery."

The St. Luke's Guild had a meeting on March 29 at St. Patricks Cathedral in Norwich. Following a brief business meeting, the Rev. Arthur Hanley, chaplain at St. Francis Hospital in Hartford, spoke on "God, Doctor and the Patient," followed by a question and answer period.

The New London Chapter of the Connecticut Heart Association presented Paul Zoll as its guest speaker for the monthly cardiovascular lecture of March 31 at the Lawrence Memorial Hospital, New London. Dr. Zoll is chief of cardiac clinic at the Beth Israel Hospital, Boston, and he spoke on "Resuscitation in Cardiac Collapse."

The monthly meeting of the William W. Backus Hospital was held on March 10. The speaker for the evening was Gordon Myers of the Massachusetts General Hospital. His subject was "Congestive Heart Failure."

Elsie M. Tytla and Carl H. Wies announced the removal of their office to 115 Huntington Street, New London, Connecticut.

NEW BOOKS IN REVIEW

MAKE INFERIORITIES AND SUPERIORITIES WORK FOR YOU. By Samuel Kahn, M.D., PH.D., Associate Professor of Psychiatry and Psychology, Long Island University; formerly Clinical Professor of Neurology and Psychiatry at Georgetown and George Washington Universities; Chief Psychiatrist, U. S. Army Induction Boards for New Jersey and Delaware. *Ossining, N. Y.: Dynamic Psychological Society Press. 1954. 184 pp. \$3.95.*

Reviewed by STANLEY B. WELD

In this volume the author points out the need for everyone to understand better his own personality and to recog-

nize that all of us develop inferiorities. The author's object in writing this book, as he states, is the "prevention of some inferiority feelings and removing understanding, or diminishing the inferiority complex from personality." The causes of inferiorities are outlined, the various types are described, and a short outline of treatment suggested.

In the middle of the book is a chapter devoted entirely to thought-provoking questions. Then there are three chapters (dental conditions, foot deviations, and longevity) where relationship to inferiorities is discussed by three contributors. The final sixty odd pages filled with biographies of famous people who suffered from inferiorities—Alexander the Great, Napoleon Bonaparte, Robert Brownning, Frederic Chopin, Albert Einstein, Harry Truman, and four Roosevelts, Anna, Eleanor, Franklin D. and Theodore, among others. One may wonder how Mr. Truman will enjoy this exposé of his nearsightedness. Mr. Einstein, on the other hand, could hardly have succumbed to any feeling of inferiority since, as the author points out, he was a true genius and as such it was difficult for inferiorities to seriously hinder his work.

DON'T WORRY—DEVELOP THE ART OF ADAPTABILITY. By William Gordon. New York: Privately published. 1954. 117 pp.

Reviewed by STANLEY B. WELD

The author John Durkan who writes under the registered pseudonym of William Gordon has done the reviewer the rather dubious honor of presenting him with an autographed copy of this book. It is not impressive, in fact, at times it grows a bit corny. Undoubtedly the author's intentions are good. Perhaps you may get more from perusing its contents than I did. There being no publisher listed, I shall be glad to lend you my copy.

DOCTORS IN THE SKY, THE STORY OF THE AERO MEDICAL ASSOCIATION. By Robert J. Benford, M.D., Colonel, Medical Corps, United States Air Force. Springfield, Ill.: Charles C. Thomas. 1955. 343 pp. \$8.75.

Reviewed by STANLEY B. WELD

This volume is a tribute to Louis H. Bauer, "the father" of the Aero Medical Association, editor of the *Journal of Aviation Medicine* for 25 years, and first commandant of the School of Aviation Medicine at Mitchel Field. Dr. Bauer was the one who first suggested the establishment of awards in recognition of achievement in aviation medicine. It was but natural then that he should be the first recipient of one of these awards, named for Theodore C. Leyster, and that the annual lecture recently introduced as a feature of the annual meeting of the Aero Medical Association should be called the Louis H. Bauer lecture.

The name of William B. Smith, a member of the Connecticut State Medical Society, appears no less than 21 times between the covers of this book for it was Dr. Smith who was elected the first secretary-treasurer of the Aero Medical Association, it was Dr. Smith who was selected as one of the original medical examiners for the Department of Commerce, and it was Dr. Smith who was a member of the first advisory committee of the Aero Medical Association to the American Board of Preventive Medicine where aviation medical examiners were first certified in November, 1953.

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.
J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.
Brit. M. J. 2:755, 1953.

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Brown, H. W.
J. Pediat. 45:419, 1954.

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This book presents in detail a chronological story of aviation medicine with accounts of its development through the various meetings of the Aero Medical Association, together with short biographies and full page photographs of each president. It is a thrilling story and one little appreciated by most practitioners of medicine. Many of the achievements in this jet and rocket age have been made possible by the research discoveries of aeromedical scientists. Of primary concern to all members of the Aero Medical Association are the health and safety of aircraft pilots and their passengers. The part that physicians have played in attaining the conditions existing today is a notable one and Dr. Bauer's leadership through the development of aviation medicine has been a major factor in its success.

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The CONNECTICUT STATE MEDICAL JOURNAL

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No. 6

THE ACUTE ABDOMEN

PHILIP THOREK, M.D. *Chicago*

ACUTE emergencies within the abdomen will always rank high if not first among those conditions which tax the skill of the general practitioner and specialist alike. It is an inescapable fact that the more accurate the diagnosis, the lower will be the morbidity and mortality. To enumerate the sixty or seventy conditions which might be encountered in acute abdominal emergencies is merely a display of cerebral muscle. After pondering over much statistical data one is impressed by the fact that only seven conditions account for 90 to 95 per cent of the pathology which makes up such emergencies. These seven conditions are:

1. Acute appendicitis.
2. Perforated peptic ulcer.
3. Acute cholecystitis.
4. Acute salpingitis.
5. Acute hemorrhagic pancreatitis.
6. Renal colics.
7. Acute coronary disease (without apologies).

Those conditions which constitute the remaining 5 to 10 per cent are too numerous to mention and cannot be discussed in a paper of this length. Space will only permit the mentioning of a few highlights pertaining to each of the seven conditions enumerated; the discussion will be kept of practical rather than theoretical importance.

ACUTE APPENDICITIS

Probably the three most dangerous words that any physician may utter are: "Only an appendix." The more one encounters this condition the more one realizes that it may present itself in a variety of bizarre forms. Despite modern chemotherapy, acute appendicitis still accounts for thousands of deaths

The Author. Chief Surgeon, American Hospital; Attending Surgeon, Cook County Hospital; Associate Professor of Surgery, University of Illinois; Professor of Surgery, Cook County Graduate School of Medicine; Attending Surgeon, Alexian Brothers' Hospital, Chicago, Illinois

SUMMARY

Seven conditions which account for over 90 per cent of the pathology in acute abdominal emergencies have been enumerated. Time and space have permitted the inclusion of only a few highlights in the differential diagnosis of each. An attempt has been made to emphasize those points which are of practical and bedside value.

annually. These possibly avoidable deaths might well be due to procrastination, purgation and poor surgical judgment. The physician is well aware of the fact that any diffuse epigastric distress which localizes to the right lower quadrant within 24 hours is acute appendicitis until proved otherwise. The patient unfortunately does not use such terminology, hence, the "Two Question Test" has been devised and has been found to be simple, accurate and extremely helpful. The test is conducted in the following way:

QUESTION NUMBER ONE

"Where was your pain when it started?" The patient points to his entire abdomen.

QUESTION NUMBER TWO

"Where does it hurt you now?" He then points to the right lower quadrant, usually McBurney's point.

From the Departments of Surgery, University of Illinois, Cook County Graduate School of Medicine, Cook County Hospital, American Hospital, and Alexian Brothers' Hospital

Presented before the Connecticut Academy of General Practice, Bridgeport, October 20, 1954

It is unfortunate that anorexia has not been stressed as the most common symptom associated with acute appendicitis. I fear diagnosing acute appendicitis in any patient who states that he is hungry. Anorexia, nausea and vomiting are three degrees of one symptom, being dependent upon the amount of distention in the appendix. Since all appendices, when acutely inflamed, are at least theoretically distended, then all patients with appendicitis should present a loss of appetite. When the distention within the appendix is pronounced the patient complains of nausea or vomiting. Fever is usually absent in early appendicitis. When the temperature rises above 100 degrees, peritoneal soiling rather than appendicitis per se is diagnosed. This of course does not pertain to children who may have a high fever in the presence of almost any early lesion.

Acute appendicitis does not produce right rectus rigidity. Although the reverse has been taught it nevertheless is a fact that it is impossible to contract one rectus muscle without contracting the other. Only if an underlying mass is present is it possible for one rectus to feel rigid. When both recti react to pressure this is muscular defense and not rectus rigidity. The importance of making this distinction is understood when one realizes that the entire course of treatment may be altered by the presence or absence of an appendiceal mass. Many signs and tests have been described under the heading of acute appendicitis but these are too numerous to mention and of too little practical value. Bidigital examination (one finger in the vagina and one finger in the anal orifice) whenever possible is preferable to rectal or bimanual examinations. By means of the bidigital examination the examiner is oriented immediately and does not confuse cervix, feces, adnexae or appendiceal masses. The usual laboratory tests which are helpful are routine blood counts and urinalyses; the differential blood count is probably the most informative.

TREATMENT

Modern chemotherapy has altered the treatment of acute appendicitis somewhat, however two schools of thought still exist. One group believes that this condition should be treated surgically whenever and wherever possible; the other group advocates conservative therapy in the so-called late or neglected case. A middle of the road type of therapy has been utilized which incorporates some of the tenets of both groups. It is mandatory to remove a leaking focus from within the peritoneal

cavity, however there are times and conditions which make this impossible. This does not apply to children since they have not acquired an immunity with which to combat the infection nor have they an omentum well enough developed to aid in localization. Therefore children should be operated upon whenever the condition is diagnosed.

PERFORATED PEPTIC ULCER

Although recent studies tend to show that this condition is becoming more frequent in females, it nevertheless appears to be a condition to which the male is particularly heir. In my practice it has been most unusual to see a perforated peptic ulcer in a female. The classical picture of the sudden onset of agonizing pain with board-like rigidity and a shock-like syndrome is too sophomoric to bear repetition.

The following highlights should be emphasized. Abdominal auscultation is of distinct value in the diagnosis of any spreading peritonitis, particularly in the case of a perforated peptic ulcer. As the peritoneal soiling spreads, the intestinal sounds diminish. The phrase, therefore, has been coined, "the wetter they are the quieter they are." This simple finding is of inestimable value. It is unusual to see a case of perforated peptic ulcer in which normal bowel sounds are heard. Another sign which helps to clinch the diagnosis is the demonstration of a spontaneous pneumoperitoneum. This results when the stomach air bubble (magenblase) makes its exit through the perforation and into the peritoneal cavity.

Exceptions to every rule are of particular importance; the forme fruste ulcer is such an exception. This term refers to a pin-point perforation which immediately seals and prevents any appreciable spillage and soiling of the peritoneal cavity. Because of this the characteristic signs and symptoms are lacking and such a patient, despite the fact that he has a perforated peptic ulcer, may walk into the doctor's consultation room. However, after obtaining an accurate history and conducting a meticulous physical examination, even such minimal perforations can be diagnosed.

Duodenal or gastric contents may escape and leak downward along the so-called paracolic gutter of the ascending colon and pool around the appendix. This would result in pseudo McBurney point tenderness causing an erroneous diagnosis of acute appendicitis and an unnecessary removal of a red looking but nevertheless innocuous appendix. In such cases the perforated ulcer usually continues to leak and death may ensue.

TREATMENT

Although there is a tendency of late on the part of some to advocate conservative treatment for perforated peptic ulcer, the consensus of opinion still leans toward early closure of the perforation. Conservative treatment is reserved for those cases which are seen 24 hours postperforation.

ACUTE CHOLECYSTITIS

That certain types of people are predisposed to certain types of diseases is a dictum that cannot be denied. The seven "F" type of person describes the usual gallbladder patient. She is the fair, fat, fertile, flatulent, flabby, female of forty. There is no dogma in medicine, hence practically any type of person may acquire any type of disease. One does not feel quite as chagrined in overlooking the rare as he does when the apparent is completely missed.

The pain which is associated with an attack of acute cholecystitis may be either constant or colicky; constant pain is due to continuous pressure upon nerve endings but colicky pain is caused by obstruction. This is an important differentiation to make since therapy differs greatly when one is treating a strictly inflammatory lesion or one associated with obstruction. The acute gallbladder patient who presents continuous pain may be tided over the acute phase on a conservative regime, whereas operative therapy in an obstructed condition becomes mandatory. It should be emphasized that gallbladder pain does not radiate to the right shoulder but rather follows the course of the seventh intercostal nerve and therefore radiates to the tip of the right scapula or the interscapular area. Any pain that radiates to the shoulder suggests an irritation of the phrenic nerve (04); this is usually caused by peritonitis with subphrenic contamination.

Although pain, a symptom, may be referred anywhere along its nervous path, tenderness, a physical finding, remains at the site of pathology. Tenderness in acute cholecystitis is usually present in the right upper quadrant close to the right costal arch. Should such tenderness be at a lower level it can only be considered gallbladder pathology if the normal tympany to percussion in the right upper quadrant is replaced by flatness.

TREATMENT

Whether to operate on an acute gallbladder or not is still a moot question. It is far better to permit the acute inflammation to subside and then do an elective cholecystectomy in a nonedematous and non-

hyperemic field; this, however, is not always possible. I have found it helpful to consider the following five questions and in this way to determine whether conservative therapy or operative intervention is the treatment of choice:

1. "Is the pain continuous or colicky (discussed previously)?"
2. What sort of risk is the patient?
3. Although some patients chronologically are 40 years of age, anatomically they may be closer to 50 or 60 years of age. The risk must be evaluated carefully to determine the type of therapy.
3. How many attacks has the patient had previously?

The result of all inflammation is cicatrization. Scar tissue has a very poor blood supply and few or no elastic fibers. If the patient has had numerous attacks it is safer to operate, whereas if it is a first or second attack conservative therapy should be considered seriously.

4. What is the duration of the present attack?
- Patients with acute gallbladder disease seen within the first 6 to 12 hours may respond well to surgical treatment; patients with acute cholecystitis of over 24 hours and surely over 48 hours are better treated medically if possible.
5. What is the progress of the present attack?

Temperature, tenderness, distention, pain, vomiting and numerous other signs and symptoms are all helpful in determining whether the patient is presently improving or getting worse. The simplest method of answering this question is by checking and charting the pulse every hour on the hour. If the pulse rises 20 beats within an hour and continues to rise this speaks for spreading and soiling and warrants surgical intervention.

True it is that the above five questions do not offer a simple yardstick to determine operability, however, each of these phases must be carefully considered and in only this way can the question as to proper therapy be answered.

ACUTE SALPINGITIS

This condition appears immediately before, during, or immediately after the menstrual period. It is most unusual for acute salpingitis to flare up in the intermenstrual period. As a rule those pelvic conditions which appear during the middle two weeks of a given menstrual cycle are usually the results of ovulation and have been referred to as mittelschmerz. Although the results of previous tubal in-

inflammations may be seen in women past the menopause, an actual acute salpingitis seen postmenopausally is a rarity. The abdominal tenderness is usually bilateral and suprasymphyseal. Bimanual and bigital examinations will reveal extreme tenderness on moving the cervix, swollen tender tubes, or adnexal masses.

A positive smear (cervical or urethral) is pathognomonic, however a negative smear does not rule out the possibility of salpingitis. Since acute appendicitis and acute salpingitis may assume atypical forms, this differential diagnosis shall always remain difficult.

ACUTE HEMORRHAGIC PANCREATITIS

In the light of present knowledge concerning the pancreas, it is not too unusual to correctly make a diagnosis of acute pancreatitis preoperatively. Those people predisposed to gallbladder disease are similarly predisposed to pancreatitis. The exact cause or causes of this condition are unknown. It is believed that any agent or agents which might activate the pancreatic enzymes within the pancreas, particularly trypsinogen to trypsin, might precipitate such an attack. Such causative agents might be presented in the form of the following alliteration: bacteria, blood, bile, body juices and booze. Any or all of these seem to have some part to play in the etiology of pancreatitis, especially if there is a communication or common channel between the common and pancreatic ducts.

It is well known that a milder form has been referred to as acute edematous pancreatitis, however, in the severe hemorrhagic (necrotizing) type, shock or a shock-like syndrome is present. The tenderness is diffuse and the rigidity is often board-like. A particular type of pain may be present and if so will impress the keen observer immediately. This pain is aggravated when the patient is on his back and is relieved noticeably when the patient assumes a sitting or upright posture. These patients may even be found in the prone position. Whenever a patient with an acute abdominal condition prefers to assume a sitting position, a pancreatic lesion must be the first to be excluded. The serum enzyme tests are helpful, particularly the serum amylase within the first 72 hours. It must be recalled that morphine may also produce an elevated serum amylase.

TREATMENT

The tendency at present is to treat acute pancreatitis medically rather than surgically. Of par-

ticular help is the use of nasogastric siphonage. By keeping the stomach empty and aspirating the hydrochloric acid, the duodenal mucosa is not stimulated to secrete secretin, and this in turn diminishes pancreatic activity. If one can be certain of the diagnosis it seems far better to reserve surgical intervention for the complications if these develop. Numerous other methods of treatment have been advocated; these can be found in any standard text or monograph.

RENAL COLICS

The word colics is intentionally written in the plural form since other substances besides an opaque calculus may produce this syndrome. Microscopic thrombi uratic debris, and a ptosed kidney might also produce such pain. Anything which can produce dilatation of the ureter may be associated with renal or ureteral colics. The typical pain in the right loin with radiation downward along the course of the ureter and into the inner aspect of the thigh or genitalia is well known. A point which is particularly valuable is the occurrence of a bradycardia with such colic. It has been stated aptly that any patient with acute abdominal pain and a bradycardia is a renal or ureteral colic until proved otherwise. The associated pseudo ileus which may be present, particularly in patients who have a history of gout or parathyroid pathology, must be kept in mind. The demonstration of a stone on the flat roentgenogram or positive findings in the urine are good corroborative evidence. Emergency intravenous pyelography at times clinches the diagnosis.

CORONARY OCCLUSION

To discuss coronary disease under the heading of "Acute Abdominal Emergencies" might appear to be sacrilegious, however, to unnecessarily open an abdomen in the presence of an acute coronary attack is to court disaster. I am using the term coronary disease as an all-inclusive one. Any pain anywhere in the body which is precipitated by exertion or emotion (pleasant or unpleasant) and relieved by nitrites is coronary disease. That such pain may be referred to the abdomen, particularly the epigastrium, is well known. Positive electrographic findings, elevated leukocyte counts and friction rubs are helpful, but these are the exception and not the rule within the first few hours. Such patients, however, if carefully examined will fail to show rectus muscle defense, particularly if such contraction is sought for at the end of inspiration.

PSYCHOLOGICAL EFFECTS OF ACTH AND CORTISONE

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SUMMARY

Every variety of clinical response to ACTH and cortisone seems to represent a summation of three principal components; each component plays a part in every reaction but its relative importance is determined by the personality structure of the individual patient: (1) the pharmacological effect of ACTH or cortisone on the total organism; (2) the meaning to the patient of an alteration in the symptoms of the disease for which he is being treated; and (3) the nature of the patient's phantasies about the action of the substance he has been given.

Among several hundred patients treated, sixteen developed psychotic-like disturbances in response to large doses of these drugs, characterized by pathological disturbance of mood, thinking, and the perception of reality, but clouding of consciousness was minimal. Small doses of ACTH and cortisone, on the other hand, induced an increased responsiveness both to inner visceral sensations and to external sensory perceptions. Observations of an 18 year old "normal" subject illustrate some of the relationships between the pharmacological effects of these drugs and the personality structure of the individual to whom they are administered. Measurable changes in the quality of perception reflect the influence of even small doses of cortisone on the central nervous system and on comparatively delicate psychological balances.

By remaining in close personal contact with the

patient while he is being given these substances, the physician can exert a steadying influence and will be in the best position to judge whether the patient can deal with any increased anxieties or whether the dosage of the drug should be reduced or, in some cases, even entirely discontinued in order to prevent serious psychological disturbance.

PHARMACOLOGICAL doses of ACTH and cortisone affect psychological as well as physiological balances. In a study¹ of over 100 patients who were given ACTH or cortisone for research study, for treatment of various diseases such as rheumatoid arthritis, asthma, and multiple sclerosis, or for adrenal insufficiency (in Addison's disease or after partial or total bilateral adrenalectomy), the three most nearly constant findings and the three most regularly occurring together were alterations in appetite, sleep and motor activity. The range of psychological response has been found to include changes in intellectual alertness and mood as well as an increase or, more rarely, a loss in the capacity for warmth and friendliness in personal relationships. Some patients felt physically more alive and became more keenly aware of external reality, but others were disturbed by feelings of unreality or of depersonalization.

Although there was a wide variety of reaction, most of the patients who received therapeutic doses of ACTH or cortisone tended to experience one or more of the following subjective sensations: some feeling of increased well-being, heightened alertness and keenness of perception, an increase in appetite, a sense of increased energy for physical or intellectual activities, a renewed interest in their surroundings and former relationships, and a greater capacity for emotional contact with others. When the administration of ACTH or cortisone was dis-

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continued, most patients tended to experience a sense of emptiness and depression, a loss of appetite, a feeling of diminished physical and intellectual energy, withdrawal of interest from their environment, and a feeling that emotional contact with other people had been lessened.

This sequence of changes in mood and sense of physical well-being tended to parallel changes in the symptoms for which the patient was receiving treatment. Energy seemed to increase with symptomatic improvement and diminished with the re-appearance of symptoms when treatment was discontinued. The same changes were observed, however, in patients whose symptoms were unaltered by treatment with ACTH or cortisone, and certain patients who showed pronounced symptomatic improvement failed to experience any subjective changes whatever. Certain patients experienced the sense of well-being in an exaggerated form, as if their increased energy was difficult to regulate within the limits of their usual personality makeup. Some of these patients described their experiences as intensely pleasurable in terms of great alertness, physical strength or intellectual prowess, and their behavior suggested a state of euphoria or elation sometimes approaching a mild hypomania. Other patients became anxious, restless, wakeful and complained of irritability, distractibility and racing thoughts. Apparently they perceived the physiological effects and the increased inner drive as threatening to their sense of emotional security. Sometimes these responses seemed to represent a general sense of alarm, as if the patient had become aware of a nonspecific danger to his existing psychological equilibrium.

Patients who did not react in the usual way to the administration of ACTH and cortisone included two "normal control" subjects who denied any subjective sensations whatever in response to doses of cortisone as high as 500 mg. a day. It could be shown that both young men were motivated to volunteer for the experiment by an unusually intense need to prove their physical and emotional invulnerability.

A few patients with neurotic symptoms of fatigue and unconscious fears connected with locomotion responded to ACTH or cortisone with great anxiety and increased inhibition against muscular movement. Two patients with anorexia nervosa experienced precisely the opposite of the expected "average" reaction, refusing to eat altogether, vomiting, com-

plaining of abdominal pain and withdrawing into a state of mutism and complete immobility. These "negativistic" responses seemed to occur when the intensification of specific psychological conflicts about eating and locomotion created intolerable anxiety and required an equivalent intensification in the neurotic inhibitions against these activities.

When the therapeutic effects of ACTH or cortisone brought about a sudden improvement in a long-standing disease process, certain patients developed unexpected complications. In some instances there was a recurrence or exacerbation of symptoms in spite of continued treatment with steroid hormones, and in other patients new symptoms were elaborated which replaced previous ones. These included transient conversion symptoms in those patients who had a pre-existing hysterical character structure. A comparatively small number of patients developed more serious psychological difficulties varying in extent from mild states of depersonalization to severe psychotic episodes, all of which were self limited and relatively brief.

Every variety of clinical response to ACTH and cortisone seems to represent a summation of three principal components; each component plays a part in every reaction but its relative importance is determined by the personality structure of the individual patient: (1) the pharmacological effect of ACTH or cortisone on the total organism; (2) the meaning to the patient of an alteration in the symptoms of the disease for which he is being treated; and (3) the nature of the patient's phantasies about the action of the substance he has been given.

Among several hundred patients treated with ACTH and cortisone at the Peter Bent Brigham and Robert Breck Brigham Hospitals between 1948 and the present, 16 developed psychotic-like disturbances in response to large doses of these drugs. Observation of these individuals gives certain clues concerning the physiological and psychological effects of these substances under less drastic circumstances. Our patients experienced a pathological disturbance of mood, of thinking, and of the perception of reality. Except for some equivocal disorientation in an elderly woman with dermatomyositis, none of our patients showed the clouding of consciousness, disorientation, or intellectual deficit that is characteristic of organic confusional states. Glaser,² reporting twelve psychotic reactions observed at the Presbyterian Hospital in New York on the other hand, describes two major patterns:

(a) a primarily affective disorder, either manic or depressive, and, more frequently, (b) an organic (toxic) psychosis similar to psychotic states occurring with Cushing's syndrome.

Different observers have, similarly, reported a correspondence or no correspondence between these psychotic states and disturbances in the electrolytes (particularly potassium depletion) or alterations in the electroencephalogram. The influence of ACTH and cortisone on existing psychoses has also been studied recently. There was no significant therapeutic effect in depressive or manic states^{3,4} or in schizophrenia.⁵ On the other hand, cortisone does have a beneficial effect in Addison's disease. It may not only ameliorate personality disturbances to a much greater extent than can be achieved by desoxycorticosterone acetate treatment but enables patients to experience a return of vigor far beyond the effect of DCA.⁶ Cortisone also corrects abnormalities in the electroencephalogram. We have noticed, however, that in certain Addisonian patients severe psychological disturbances were apparently precipitated by relatively small doses of cortisone, and others have reported exacerbation of an existing psychosis and the precipitation of psychosis in response to cortisone.^{7,8}

There seems no reason to doubt the validity of these various types of observation even though some of them at first look as though they might be contradictory. Forces which elicit a functional response after all may also produce relatively irreversible structural changes with impairment and eventual destruction of cells and tissues. The fact that some individuals experience such profound psychological effects from taking ACTH or cortisone in the absence of any gross disturbances of electrolyte balances or of general toxic damage to brain tissue requires explanation in terms of more subtle biochemical influences on psychological processes—presumably more like the ordinary response of the organism to life stress.^{9,10}

ACTH and cortisone have been found to induce an increased responsiveness both to inner visceral sensations and to external sensory perceptions. A number of the patients who became anxious experienced an exaggerated sensitivity to light or noise. This apparently represented pathological intensification of the special effect of pituitary adrenal hormones on perception. It seems possible that this effect, primarily a heightening of perception, helps to mobilize the individual for action. Thus the qual-

ity of perception as well as the nature of behavior and performance indicate the extent to which a useful sharpening of alertness has been exceeded.¹¹

Observations of an 18 year old filling station attendant who volunteered as a "normal" subject illustrate some of the relationships between the pharmacological effects of these drugs and the personality structure of the individual to whom they are administered. He was given 15 mg. of dextrine by mouth and on another occasion was given 40 units of ACTH gel intramuscularly. This dose is routinely used as a test of adrenal responsiveness. Neither the subject nor the investigating psychologist and psychiatrist knew the order in which these substances were given. On each of the two occasions he was given a placebo along with the test substance and on both occasions he was given a substance by mouth and an intramuscular injection. He was seen by the psychiatrist and the psychologist before receiving any substances and during the period when he was presumably under the influence of each them. The data were reported independently by the psychiatrist and the psychologist. Any apparent changes on each of the test days were described and an attempt was also made to identify the substance. The psychologist also attempted to predict the general type of psychological reaction on the basis of the Rorschach and other psychological test data obtained during the control period. The Rorschach picture of the subject obtained during the initial control period and without any biographical data was that of an easily disturbed person given to religious preoccupations and prone to severe guilt. Fears of becoming the object of bodily attack were prominent, and the Rorschach indicated a potentiality for delusional beliefs concerning the effects and influences of external forces—in other words, a potentiality for psychotic projection.

The psychiatric interviews disclosed a background of divorced parents. The subject slept in a double-decker bed above his father, for whom he cooked and kept house according to an obsessive ritual upon which his father had insisted. From time to time his father struck him and challenged him to demonstrate his manhood by successfully fighting back. The subject felt sure that he could easily overwhelm his father physically and was afraid of yielding to his belligerent impulses. It developed that the father had recently gone through a psychotic episode with mental hospitalization. The subject made use of the interviews to seek advice on a conflict

between his religious teachings and his sexual behavior.

While under the influence of dexedrine, he expressed a conviction of increased speed of reaction and improved motor coordination, but sensory motor tests revealed no objective improvement—not even the increase which might have been expected as the result of practice effect. After he had received the 40 units of ACTH, the Rorschach demonstrated a loss of his pretreatment ability to recognize details as integrated parts of a whole picture, and his perception had now become narrowed to the details themselves. Although he now saw more shapes in the ink blots than before he was given the ACTH, it was much more difficult for the psychologist to connect what the subject reported with the actual forms which appear on the test cards. Thus his perception under ACTH could be characterized as narrowed, less well integrated, and with a deterioration in his ability to distinguish private phantasies from objective reality.

From his interviews the psychiatrist was able to make the correct distinction between the two substances largely on the basis of the subject's loss of appetite while on dexedrine, as contrasted to his increased appetite after he had received the ACTH. He appeared somewhat stimulated when under the influence of dexedrine in contrast to his decreased spontaneity and yawning, which has been described as characteristic of the response of many people to small doses of ACTH. The tendency toward a delusional type of projection demonstrated by the psychological tests on the day he had been given ACTH was consistent with the previously observed effect of ACTH as well as cortisone and Compound F on certain particularly sensitive individuals.

The use of placebos and tests of perception and performance are necessary supplements to the verbal reports of patients concerning the psychological effects of a substance like cortisone because we are dealing with one of the wonder drugs with all that this implies in terms of suggestion and phantasy. The fact that these substances can actually produce such profound effects on the central nervous system helps to dramatize and to intensify the symbolic meaning to patients of ingesting these substances. Furthermore, this aspect becomes particularly important in patients who because of adrenalectomy or Addison's disease have actually become dependent on substances like cortisone for the maintenance of health and life.

A woman with Cushing's syndrome who had undergone a partial adrenalectomy became very depressed after her cortisone had been withheld for a number of weeks in order to test the responsiveness of her remaining adrenal tissue. She turned her face to the wall and refused to say very much. When she was then handed a cortisone pill and told what it was, she sat up, became instantly cheerful and chatty and the depression disappeared before she had even swallowed the substance.

A 40 year old patient with an unexplained edema had responded with euphoria to small doses of cortisone. Some months later, after it had been determined that the edema was a symptom of his rapidly advancing Hodgkin's disease, he was given another course of cortisone. This was done because the swelling of his lymph nodes had recurred almost immediately after his last nitrogen mustard treatment and it was hoped that cortisone would slow down the advance of the disease. The patient explained that he did not like to take something like cortisone because it shuts off the action of his own adrenals and that he did not like to be dependent on a substance whose effects were so poorly understood. He spoke specifically of his breasts having become large and tender after having taken cortisone, and he was also aware that cortisone tends to cause the retention of fluid. He remembered further that when he was on cortisone originally he had felt overstimulated. He remarked, "Wonder drugs have many disadvantages. They seem to help you in one way and then weaken you somewhere else." He felt that cortisone may have been responsible for his having less resistance to infection. He also felt that if he should be put on cortisone now it might be the beginning of the end—a sign that nitrogen mustard could not help him and that, therefore, he was really slipping. He was given 100 mg. a day but reported no exhilaration this time and now, in contrast to his earlier experience (before he knew that he had a fatal disease), he felt that the cortisone was distracting, disturbing and confusing. He felt overly relaxed and without interest and initiative. He felt as though everything was at a distance from him and was aware that these symptoms were very similar to what he had described the previous week as a response to giving up cigarettes. He felt a little more cheerful after starting to smoke again but continued to be aware of considerable anxiety, which he attributed to the effect of the cortisone. He felt anxious and apprehensive

about almost everything he did and felt tense and keyed up rather than exhilarated.

This patient's response to cortisone before and after he realized that he had a fatal disease illustrates the observation that the same dose of this drug may have a different effect on a person under differing psychological conditions. The variety of psychological response to the same dosage in different individuals, moreover, suggests that physiological and psychological balances characteristic for any given individual have a great deal to do with the manner in which he responds to the administration of one of these hormonal substances. Unfortunately, we are not yet in a position to make exact predictions concerning which individuals are likely to become psychologically disturbed by the administration of these substances. The fact that an individual has had previous emotional difficulties should certainly be taken into account, but even patients with a history of previous psychotic episodes do not necessarily manifest any special vulnerability to drugs like cortisone.¹² Theoretically, on the other hand, every individual may reach some threshold of tolerance under sufficiently high or prolonged doses beyond which metabolic or psychological balances become so much disturbed as to impair the individual's capacity for physiological homeostasis or for the maintenance of emotional balance.

Measurable changes in the quality of perception reflect the influence of even small doses of cortisone on the central nervous system and on comparatively delicate psychological balances. There is reason to hope that research in progress will provide more specific indications and guidance concerning treatment. At the present time, however, the best practical advice to internists who are administering these substances is to learn as much as they can about the patient's psychological makeup as well as his personal situation before giving these drugs. By remaining in close personal contact with the patient while he is being given these substances the physician can exert a steadying influence and will be in the best position to judge whether the patient can deal with any increased anxieties or whether the dosage of the drug should be reduced or in some cases even en-

tirely discontinued in order to prevent serious psychological disturbance.

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DIABETIC PREGNANCIES AT HARTFORD HOSPITAL

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IN the 14 year period, 1940-1953, 99 pregnancies in diabetic women have been observed at the Hartford Hospital. To present certain data collected from these cases is the purpose of this paper.

FETAL SURVIVAL

Of the total 99 pregnancies, eight were terminated before the fifth month. Five hysterotomies were done for therapeutic reasons. Of these, three were performed because of severe toxemia in early pregnancy, and two were done because of psychoses, impending or full-blown. Of the remaining three abortions in this group, one was probably self-induced and two were spontaneous during the early weeks of the pregnancy. In addition to the eight, there were 12 stillborn infants and eight neonatal deaths yielding a total fetal survival of 71 cases (71.7 per cent). Omitting the eight pregnancies

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SUMMARY

- 1. Ninety-nine cases of pregnancy complicating diabetes are reported.
- 2. The rate of fetal survival in 91 cases continuing six months or more was 78 per cent. Factors influencing this survival rate are discussed.

terminated before the fifth month, there were 91 cases with 71 surviving babies—78 per cent fetal survival (Table I).

MANAGEMENT

In the prenatal care and choice of delivery there has been a good deal of diversity in this series of

TABLE I
FETAL SURVIVAL

YEAR OCT. 1-OCT. 1	NUMBER OF CASES	ABORTION BEFORE 5 MONTHS	LIVING BIRTHS	PER CENT	STILLBORN INFANTS	NEONATAL DEATHS
1940-1941	2	0	2		0	0
1941-1942	8	1 ? self-induced septic	5		1	1
1942-1943	7	0	5		2	0
1943-1944	4	0	2		1	1
1944-1945	4	1 therapeutic	2		0	1
1945-1946	7	0	5		2	0
1946-1947	10	1 therapeutic	6		2	1
1947-1948	16	1 therapeutic	9		3	3
1948-1949	7	1 therapeutic	6		0	0
1949-1950	7	1 therapeutic	5		1	0
1950-1951	9	0	9		0	0
1951-1952	11	1 spontaneous 1 ? spontaneous	9		0	0
1952-1953	7	0	6		0	1
Total	99	8	71	72	12	8
Corrected*						
Total	91	—	71	78	12	8

*Omitting 8 pregnancies terminated before 5th month

cases. Sixty-six of the 91 were private patients and 25 were ward service cases. Twenty-three obstetricians handled the private patients. The maximum deliveries by any one obstetrician was ten. Twenty internists controlled the diabetes. Of these, one internist handled 32 of the 66 cases, and the most cases supervised by any other internist was five. Thus the diabetic treatment was more uniform than the obstetrical management. In most cases a fairly liberal (over 200 Gm.) carbohydrate diet was used and high protein intake was prescribed in a number of cases. Salt was usually restricted and the insulin dosage was controlled by the urine test taken before meals and at bedtime rather than by blood sugar determinations. Parenteral administration of progesterone and stilbestrol in oil was used with increasing frequency. Weight gain was controlled as carefully as possible. Delivery was generally accomplished by cesarean section unless terminated spontaneously before the 37th or 38th week.

MATERNAL FACTORS IN FETAL SURVIVAL

Of the 91 pregnancies carried beyond the fifth month, 56 women had one baby in this series. Thirteen women had two babies, and three women had three babies—a total of 72 women. Their average age was 27 years. The duration of diabetes in these women and its relation to fetal survival is shown in Table II.

TABLE II
DURATION OF DIABETES

	LESS THAN 5 YEARS	5-9 YEARS	10-19 YEARS	20 YEARS AND OVER	TOTAL
Number of cases	41	20	23	7	91
Surviving infants	32 (78%)	15 (75%)	18 (78%)	6 (86%)	71 (78%)
Stillborn infants	7	1	3	1	12
Neonatal deaths	2	4	2	—	8
Fetal wastage	9 (22%)	5 (25%)	5 (22%)	1 (14%)	20 (22%)

From these figures, apparently no significant conclusion as to the effect of the duration of diabetes on fetal survival can be drawn. The average duration of diabetes for all cases was 8.1 years. The relation of the type of delivery to fetal survival is shown in Table III, and indicates that abdominal delivery is superior to vaginal delivery in obtaining a live baby. In the 51 cases in which cesarean section was performed, delivery averaged 22.7 days early. In the 40 cases in which vaginal delivery occurred, it was an average of 29.9 days early. Cesarean section was done more frequently on the

private service than on the ward service (Table III). Scrutiny of the spontaneous delivery series shows a large number of prenatal deaths, and mothers with no prenatal care who entered the hospital in labor or toxemia.

TABLE III
TYPE OF DELIVERY

	ABDOMINAL	VAGINAL	TOTAL
Number of cases	51	40	91
Surviving infants	47 (92%)	24 (60%)	71 (78%)
Stillborn infants	1	11	12
Neonatal deaths	3	5	8
Fetal wastage	4 (8%)	16 (40%)	20 (22%)
Ward cases	10	15	25
Private cases	41	25	66

INCIDENCE OF TOXEMIA

The relationship of toxemia in the mother to survival of the fetus is shown in Table IV. Toxemia was considered to exist if one or more of the following findings were present: blood pressure higher than 140 systolic or 90 diastolic, albuminuria, hydramnios, or edema. The incidence of toxemia was 47 per cent (43 cases). Fetal survival in this group was 76 per cent (33 infants) compared to a fetal survival rate of 79 per cent for nontoxic mothers.

EFFECT OF TREATMENT WITH HORMONES

Of the 91 pregnancies, hormone therapy was given in 41 cases. As a rule both progesterone and stilbestrol were given parenterally, according to schedules devised by Dr. Priscilla White. In occasional instances patients received only oral stilbestrol. Relationship of hormone therapy during pregnancy to fetal survival is indicated in Table IV. In the treated cases only five infants of 41 births were lost—12 per cent fetal wastage; whereas 15 infants died in the untreated group of 50 cases—a fetal loss of 30 per cent.

TABLE IV
RELATIONSHIP OF TOXEMIA OF MOTHER TO SURVIVAL OF INFANT AND EFFECTS OF
HORMONE THERAPY ON FETAL SURVIVAL

	NUMBER OF CASES	LIVING BIRTHS	STILLBORN INFANTS	NEONATAL DEATHS
Mother toxic	43 (47%)	33 (76%)	7	3
Mother nontoxic	48 (53%)	38 (79%)	5	5
Total	91 (100%)	71 (78%)	12	8
Received hormone therapy				
during pregnancy	41	36 (88%)	2	3
No hormone therapy	50	35 (70%)	10	5
Total	91	71 (78%)	12	8

FETAL DEATHS

Of the total of 20 fetal deaths, 12 were stillbirths and eight were neonatal deaths. Details are listed in Table V for the 12 stillbirths, of which nine were premature chronologically, although six fetuses

weighed over 7 lbs. The neonatal deaths are listed in Table VI. Of the eight cases, two infants exhibited congenital defects incompatible with long survival. One infant had a subdural tear and hemorrhage. The cause of death in the other five was ascribed to prematurity and atelectasis.

TABLE V
PRENATAL DEATHS

CASE NUMBER	DAYS EARLY	BIRTH WEIGHT LBS. OZ.	FETAL CONDITION	MATERNAL FACTORS
4	20	7-1	macerated	edema hypertension 135/105
15	37	8-6	autopsy: hepatomegaly and cardio- megaly with subepicardial and sub- pleural hemorrhages, atelectasis	obesity (300 lb.) hypertension 204/120 albuminuria
16	4	9-14	died 10 days before birth	hydronephrosis B.P. 140/90
19	17	—	"large baby" delivered by cesarean section	slight edema and rise of B.P. 10 mm. Hg.
28	0	8-9	macerated	toxic B.P. 160/102
30	28	7-8	macerated	B.P. 150/100
36	108	—	spontaneous delivery of dead 5 month fetus on way to hospital	diabetes began at age of 8 duration 17 years
38	0	12-5	macerated	hydramnios B.P. 150/110 diabetes not known before delivery
40	0	6-0	macerated dead 27 days before birth	
51	2	6-0	dead for a month	poor diabetic control no toxemia. no hormones
54	90	—	spontaneous delivery at home of macerated 6 month fetus	uncooperative childhood diabetic with 17 previous hospital admissions
71	90	—	spontaneous delivery of 6 month fetus	acidosis and pneumonia poor control of diabetes gravida X, para V.

TABLE VI
NEONATAL DEATHS

CASE NUMBER	SURVIVAL TIME	REMARKS
6	3 weeks	Had congenital defects: spina bifida with Arnold-Chiari syndrome. Died of meningitis
20	3 days	Cyanotic at birth with respiratory difficulty. Diagnosis: Prematurity, atelectasis
23	1 day	Premature labor 37 days before E.D.C.
33	3 days	Multiple congenital defects including hydrocephalus and congenital cardiac defect
42	1 day	Prematurity, atelectasis
47	2 days	Prematurity, atelectasis
49	12 hours	Atelectasis
94	3 hours	Subdural tear, prematurity, atelectasis

COMMENT

A series year by year as presented has so many variables that scientific comparisons cannot be made. We are sure that careful medical care with a cooperative mother is invaluable. Over the past 15 years a teaching diabetic service has been established with full time, trained diabetic nurses assisting and we are sure this has improved the diabetic care over the hospital as a whole. As to hormone therapy, we believe it helps enough so that the fetus is not as large and water-logged, and has a better chance of survival.

In spite of the diversity of personnel involved, there is much give and take, and enough interest raised to bring diabetic-obstetrical care to a high level.

Maternal factors influencing fetal survival are felt to be meticulous diabetic care, restriction of salt, control of weight, and selection of the delivery date and method by medical-obstetrical consultation.

Hormone therapy would seem more important than toxemia of pregnancy, and the newborn infant seemed easier to care for in treated than in untreated cases. Infant care under an interested pediatrician was carried out by oxygen for three days, dehydration (no fluid for three days), and treating each infant as premature.

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THE PROBLEM OF INTRA-ORAL CARCINOMA

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INTRODUCTION

The high incidence of intra-oral carcinoma and the misconceptions existing regarding its treatment justify a brief review of the problem. The misconceptions are partly based upon the fact that therapeutic concepts in this field are in a state of change, and misunderstandings also are related to the fact that the treatment of such patients does not clearly fall to one specialist, being somewhere among the provinces of the otolaryngologist, oral surgeon, radiologist and general surgeon. The fact that intra-oral carcinoma is to some degree an interspecialty problem is often unfortunate for the patient, because the injudicious use of one modality, be it irradiation or surgery, in the initial approach to treatment may nullify any possibility of later salvage.

NATURAL HISTORY

Of the many forms in which neoplastic disease may occur above the level of the clavicles, present attention will be arbitrarily limited to the largest group, those tumors arising from the squamous epithelium of the upper alimentary tract—and more especially the epidermoid carcinomas. Grossly these lesions make their appearance as ulcerations upon the mucosa, lesions which are usually readily perceptible to the host because of the ample sensory innervation of the mouth. For many reasons, however, there occurs frequently a considerable lapse of time before the patient reaches a doctor who confirms the diagnosis by biopsy. The length of this time lapse may determine whether involvement of the regional nodes by tumor occurs. The order of involvement of cervical lymphatics follows a fairly uniform pattern according to the location of the primary in the mouth. An important characteristic of this disease is a pronounced tendency for localization of the lymphatic involvement above the clavicle and for the rather infrequent occurrence of more distant metastases except as a late development. Untreated, the progressive growth of the tumor

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SUMMARY

A brief review is presented of the problem arising from intra-oral cancer. The importance of being certain that the initial treatment be correct is emphasized, as is the value of handling these patients as a team enterprise, combining the specialized knowledge from several branches of medicine.

leads to involvement of contiguous structures with impairment of the functions of respiration, deglutition and phonation and later to hemorrhage, secondary infection, inanition, severe pain and pulmonary suppuration. The progression from the simple mucosal ulceration to the advanced stage of disease is inevitable unless adequate treatment is carried out.

TREATMENT

I. GENERALITIES

In general the primary treatment of the intra-oral epidermoid carcinoma will be by irradiation, usually a combination of external and interstitial methods. In lesions properly situated and not too far advanced, a good per cent of cures will result from this alone. A plea is made, even in the simplest situation, for management of these patients as a team enterprise, bringing together with the referring physician, the radiologist, otolaryngologist, oral and general surgeons, because only by such a pooling of talent can the best interests of the patient be served. Again, the critical importance of having the initial treatment properly chosen and properly administered is stressed. Should involved cervical lymph nodes be found, a radical neck dissection is carried out if proper indications are met. In general metastatic node involvement is not curable by irradiation.

Surgical treatment of the primary intra-oral tumor

is sometimes employed rather than irradiation. Some of the reasons are listed below:

1. In certain lesions of the anterior tongue, the choice between irradiation and surgery is an optional matter, determined by the judgment of the physician.

2. Progression of the intra-oral lesion to a degree that bone invasion has occurred. Resection is indicated, usually comprising removal of the primary lesion, a portion of the mandible and the ipsilateral lymph nodes en bloc. By such measures suprisingly advanced lesions may be cured and the disability, functional and cosmetic, may be minimized. Other advanced lesions may be, by reason of their extent, deemed inoperable, and assigned to palliative irradiation. Certain of these will recede under treatment to a degree where they may later enter an operable category.

3. Lesions which do not regress or which recur after irradiation.

4. In certain circumstances, noncurative resections for palliative reasons such as the removal of necrotic tumor masses.

In some centers the concept exists that ideal management, even of smaller lesions, should consist of resection of the primary lesion and regional lymphatics in continuity, with or without irradiation. This concept may prove to be correct but as yet evidence confirming this does not appear to be available in the literature.

A few patients are seen in whom the extent of disease requires either that nothing curative be done and the diseased allowed to progress to its natural outcome, or that various extensive resections be carried out which, although extreme, represent a lesser evil than the relentless ravages of the disease itself. When undertaken, such procedures may result in varying degrees of disability, both cosmetic and functional, for the relief of which again the team approach becomes necessary, employing plastic surgeon, prosthodontist, etc., to restore the patient, and then the various social services to achieve some degree of rehabilitation to society. There remains, however, a fair number of patients in whom the most that can be offered is some form of palliation, either by radiological or surgical means. Such patients are usually those in whom the diagnosis has been delayed until the disease has reached a fairly advanced stage.

II. SPECIFICITIES

Having outlined the general approach to treatment, a few words are in order regarding the treatment of epidermoid lesions in specific sites:

A. Lip

Lesions which have not deeply involved the muscle may be cured by radium moulage. Larger, deeper cancers are managed by excision with reconstruction of the lip by an appropriate plastic procedure. Cervical node involvement constitutes an indication for some variant of the neck dissection. Wide, midline-straddling, anaplastic lesions with a history of rapid growth may well require neck dissection even though nodes are not palpable.

B. Tongue

Small, accessible lesions near tip or border may be cured either by irradiation or excision. Larger cancers with involvement of contiguous structures are managed by excision en bloc if feasible; if not, irradiation is employed. As in all neoplasms in this area, a critically important phase of the management is the vigilant follow-up of the patient to detect cervical node involvement, failure of response to radiation, or local recurrence at the earliest possible date.



FIGURE 1

Carcinoma of the lateral border of the tongue in an eighty-two year old man. Treatment consisted of hemiglossectomy

C. Floor of Mouth

Essentially the same principles as above (tongue) apply. The frequency of contralateral node involvement is to be borne in mind, particularly in lesions near the midline.

D. Alveolus

The intensity of irradiation necessary to achieve cure results not infrequently in radionecrosis of bone, for which reason it is felt that many alveolar ridge lesions are better treated surgically, usually with concomitant cervical lymph node dissection.

E. Buccal Mucosa

Because many of these lesions are flat and accessible, a good percentage of cures will result from irradiation, but again a careful watch is in order, so that other modalities may be employed, should irradiation fail.



FIGURE 2

Carminoma of the buccal mucosa and adjacent upper alveolus in a sixty year old white male. Treatment was by irradiation with good immediate result

F. Pharynx

The potentials of cure by surgical resection diminish as pharyngeal levels are reached and irradiation offers a more rational approach. Certain hypopharyngeal cancers, however, may justifiably be managed surgically. In these cases involvement of the larynx either primarily or secondarily may necessitate its concurrent removal. If the extent of hypopharyngeal involvement is great, reconstruction of alimentary continuity presents a fair problem, requiring utilization of free or pedicled grafts.

G. Complex Lesions

Unfortunately cancer does not respect the neat anatomical subdivisions under which it has been considered above, but frequently will be seen involving tongue, floor of mouth, and alveolus or other combinations of structures. In such advanced lesions, the complexities preclude generalities regarding treatment.

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THE ENLARGED FONTANELLE: CRANIAL DYSOSTOSIS AND SYNOSTOSIS

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SUMMARY

The author discusses two of the causes of enlarged fontanelles, viz., cranial dysostosis or defective bone formation, and synostosis or bony ankylosis. The literature on these two conditions is reviewed and two cases from the author's own experience are cited in detail.

The large anterior fontanelle was the presenting sign in both cases described. Paradoxically, the delayed

closure of the fontanelle was due to opposite processes in each case. In the one instance it was due to failure of the sutures to close. In the other instance it was due to the lack of formation of sutures, which caused the brain to exert increased pressure in the area of the fontanelle in particular, thereby keeping it open.

The presence of large fontanelles should remind the clinician of the rare causes, such as cleidocranial dysostosis and synostosis, as well as the more common etiological factors. X-ray studies are a valuable aid in diagnosis and prognosis and surgical intervention offers the only relief.

APERSISTENTLY enlarged anterior fontanelle is rarely seen these days. This is in a large measure due to the infrequent occurrence of lues and rickets, which in turn is due to relatively recent advances in prophylaxis and therapeutics. Hence our thinking must be reoriented in the direction of the unusual diagnostic possibilities. Thus we should consider such causes of enlarged fontanelles as: hydrocephalus, hypothyroidism, Mongolism, brain tumor, progeria, cranial dysostosis, and synostosis. Most of these entities can be readily diagnosed from the other signs and symptoms that accompany fontanelle enlargement. However, in almost all of these conditions x-ray studies are valuable in either discovering or confirming the diagnosis. Perhaps the greatest value of roentgenology is in detecting the abnormality in an early stage, prior to the full development of clinical signs. This affords the most favorable time for the application of whatever therapeutic measures might be available. An example of this is to be found in cranial synostosis where early surgery can correct a condition that might otherwise result in damage to the brain.

The opportunity to observe examples of the types of cases referred to above has occurred twice recently in the author's practice. The first case is one of cleidocranial dysostosis.

CASE REPORT

This boy was first seen at the age of 9 months. His birth weight was 8 lbs. Past history and family history were irrelevant and definitely negative for osseous abnormalities, but no x-ray studies were available.

The mother complained that he was not gaining weight, since he had gained only 14 oz. from his sixth to eighth month. However, his development was normal insofar as he had his first teeth at three and one-half months, and could stand with support at eight months. He also had been given 0.9 cc. of Trivisol (1500 U vit. D) daily since the age of one month and some additional vitamin D recently, because of his "rachitic" look.

On examination his general appearance was that of an underweight infant with an unusually large anterior fontanelle and prominent parietal bossing. His length was 28 $\frac{1}{8}$ "; head circumference, 16 $\frac{1}{2}$ "; chest circumference, 18 $\frac{3}{8}$ "; abdominal circumference, 20 $\frac{1}{4}$ "; his weight was 18 lbs. (average normal, 20 $\frac{1}{4}$ lbs.). The enlarged anterior fontanelle was very striking; it measured 5.75 cms. by 7.75 cms. on each diagonal and continued posteriorly into a widened sagittal suture. One competent observer had felt craniorabes to be present. The bossing was so pronounced that it gave his cranium the classical appearance of a hot cross bun. His facial appearance was also unusual because of the depressed and broadened bridge of the nose, along with pronounced inner canthal folds. (The former is definitely part of the dysostosis, and the latter suggested facial hypertelorism.)

The only other notable abnormality was in his clavicles. On this first examination they appeared normal, but the shoulders could not be flexed anteriorly to any unusual degree. However, on re-examination following the discovery by x-ray that the acromial ends were absent, it was found that the sharp ends of the clavicles could be palpated just medial to each shoulder.

In view of the history of adequate vitamin D intake and the lack of any further corroborative evidence of rickets, a detailed study of his osseous abnormalities was undertaken. X-rays revealed the true nature of his condition; they are presented in figures 1, 2 and 3. Other x-rays showed that he had one carpal epiphysis and one tarsal epiphysis at the age of nine months. (There were, however, no other signs—physical or mental—of hypothyroidism.) His blood chemistry was as follows: calcium 10.3 mg. per cent; phosphorus 5.4 mg. per cent; phosphatase 8.4 units. VDRL was negative for syphilis. Protein bound iodine studies were refused.

His progress up to the time of this report (age 1 year, 10 months) is quite interesting. His facial appearance and shape of head have improved a great deal towards normal. The defects in his skull feel much firmer, as if bone were being formed in them. His clavicular defects, however, are much more noticeable. His shoulders sag noticeably as well as does his entire thoracic cage. While it is not possible to approximate his shoulders anteriorly as completely as in classical cases having complete absence of both clavicles, they can definitely be flexed more than normal. The short clavicles can be seen as well as felt under the skin. Along with the sagging and lateral flattening of his thorax there is an extreme protuberance of the abdomen. His teeth are adequate in number, but there is some pitting of the enamel. His general mental and physical condition is satisfactory, although he is still underweight (23 lbs. 3 $\frac{1}{2}$ oz. compared to 26 lbs. for his height of 33 inches).

Just to make matters even more interesting, the following occurred. A few weeks ago the mother complained that this child was vomiting. She admitted that, despite definite orders to the contrary by the author, she had been giving him 20,000 units of vitamin D daily for several months. Urinalysis was done, but no abnormal elements were present and the Sulkowitch test was negative for excess calcium in the urine. Chemical and complete x-ray studies were refused, but the roentgenogram of the chest which is reproduced here (taken after this episode) did not reveal any effect on the clavicles or ribs. Thus an experiment was done unintentionally to indicate that this dosage of vitamin D has no effect on the clavicular defect.

DISCUSSION

This patient presented the usual signs of cleidocranial dysostosis: namely, persistent cranial and clavicular defects. However, mention should be made of the fact that many other bones may be affected; and conversely, delayed fontanelle closure or absence of clavicles may each constitute the sole expression of the disease.¹⁵ Something that is not only seldom mentioned but even denied in descriptions of this condition is the fact that involvement of the

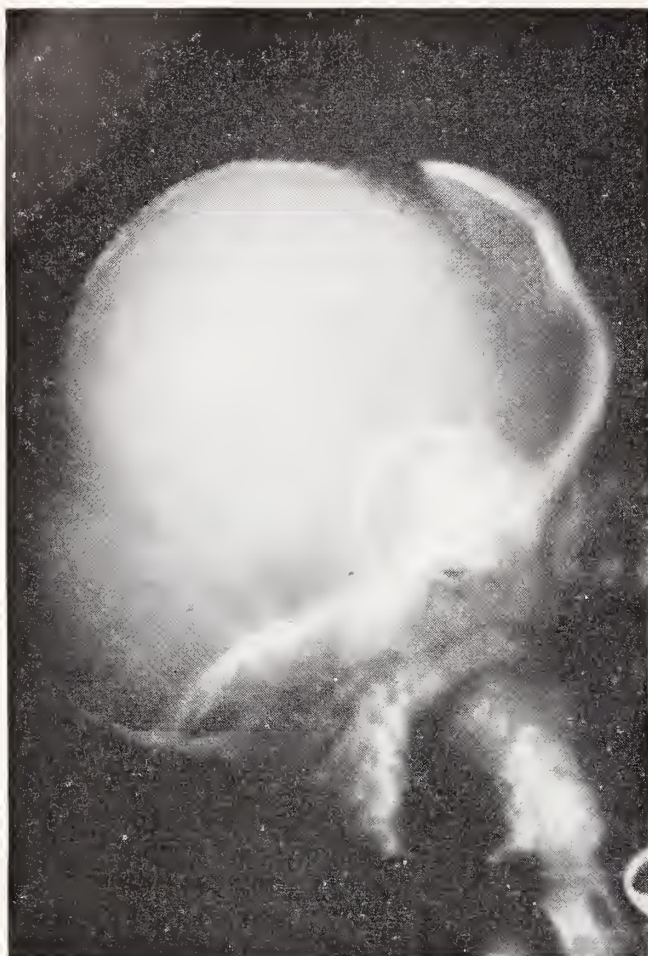


FIGURE 1

Cleidocranial dysostosis: There is retardation of ossification of the bones, with widening of the sutures and fontanelles. There are wormian bones in the lambdoid suture.

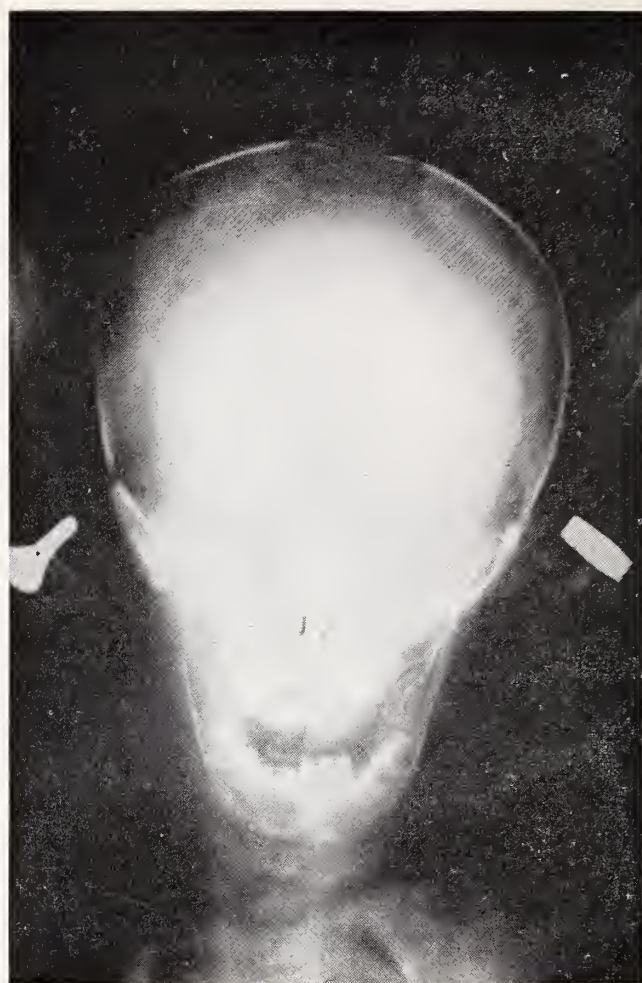


FIGURE 2

Cleidocranial dysostosis: This view of the skull shows the extreme widening of the sagittal suture and anterior fontanelle, with sutural bones present.

central nervous system can occur.^{16,17} Mental and motor defects are present in such instances; fortunately such complications are rare and were absent in the above case.

Our patient, nevertheless, presented certain unusual features. First of all this case was discovered at a rather early age compared with most cases reported. This prompted a study of the literature to determine the earliest age at which this condition was ever found. Secondly, the possibility of endocrine etiology was suggested by the delay in epiphyseal maturation, insofar as this can be a sign of hypothyroidism. Therefore the question of causation, particularly hormonal, was the object of another search in the literature.

It was noted early in our reading that credit for the initial description of this disorder belongs to

Meckel, who reported it in 1760.² Marie and Saiton are usually given credit for the first paper on this illness, which report appeared in 1897. At least 250 cases have been written up or reported up to 1938.³ Fitchet⁴ has written a very complete paper on this subject.

There are at least five reported cases in newborns.^{3,4,6} It is interesting to note, however, that the average age at which most cases were found was twenty-two years.² This is a reflection on a failure to detect this condition earlier. It is to be noted also that many cases were first discovered by dentists. They recognized the persistence of deciduous teeth in a given patient. Realizing that this might be a sign of cleidocranial dysostosis, they advised further studies which often confirmed their suspicions.

The literature was searched for the etiology,

particularly endocrine, of this condition. To begin with it must be admitted that the basic cause is unknown. The fault probably lies within the germ plasm. It can be directly hereditary or familial, but many sporadic cases occur.¹ It has been known to recur through as many as four generations.⁸ Our case showed no apparent familial or hereditary tendency to date, but the possibility of an endocrine etiology, has been studied repeatedly.^{9,10,11,12,13,14,22} Epiphyseal delay in cleidocranial dysostosis has been noted by others, but detailed chemical studies, B.M.R., heredity, and animal experimentation studies have all failed to substantiate the thesis of hormonal causation. The etiologic agent is probably in the form of a mutant that does not persist for more than a few generations, if at all.

The fortuitous experiment on the patient presented above indicated that large doses of vitamin D had no effect on the clavicular deformity. This prompted a further search for a similar test of the effect of this vitamin. The only remarks found were those of Niles²² to the effect that, although rickets was present in some of his cases, it definitely could not be considered as a causative factor. This is apparent, both from the fact that cleidocranial dysostosis must

start in intrauterine life (6 weeks fetus), and the fact that it continues into adult life. Fitchet⁴ also agrees that rickets is not related in any way.

It was carefully noted in studying the literature that in none of the articles was the persistent enlargement of the anterior fontanelle emphasized as a presenting sign.

Another unusual condition to be considered when confronted with delayed closure of the fontanelle is cranial synostosis. This defect occurs only in those cases having closure of the lateral third of each coronal suture, which allows the fontanelle to remain open and to enlarge. This was the situation in our case.

CASE REPORT

M. G., female, was born spontaneously on April 14, 1951 after a normal gestation. It was noted shortly after birth that



FIGURE 3

Cleidocranial dysostosis: There is extreme hypoplasia of the right clavicle, but the medial half of the left clavicle is present. Note the drooping of the thoracic cage. (The cardiac shadow is distorted, due to the prone position of the patient.)

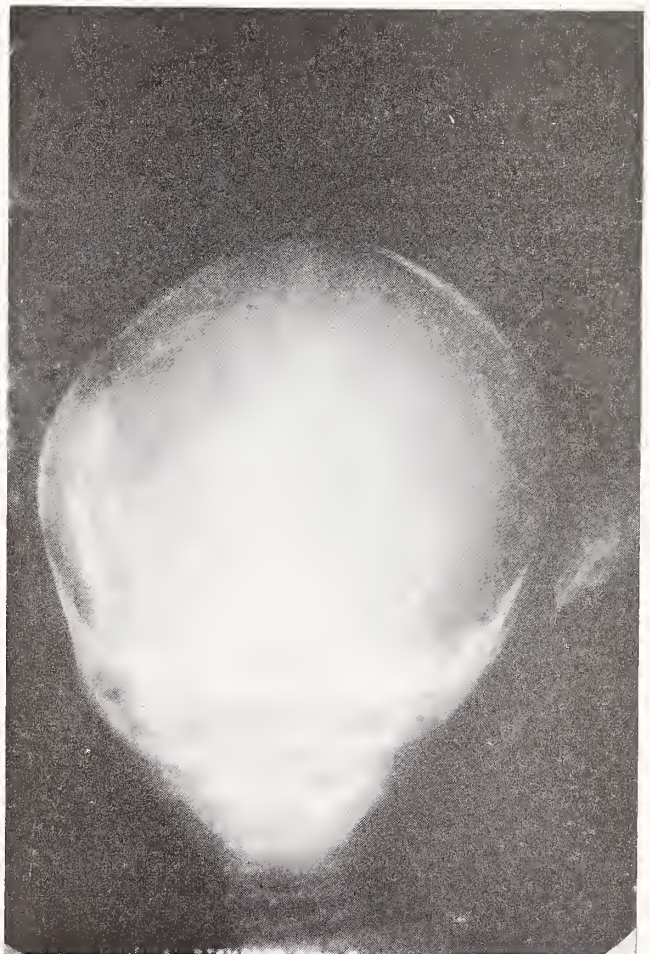


FIGURE 4

Cranial stenosis: This view shows the bulging of the sagittal suture and anterior fontanelle due to intracranial pressure. The tower shape of the skull is clearly apparent.

the anterior fontanelle and sagittal suture were wider than average. This condition became more pronounced as time went on. On June 8 the suture was 2.5 cms. wide and on July 6 it was 3 cms. wide; the anterior fontanelle was co-extensive with the suture. Her development, however, proceeded normally. It was even advanced, since she was able to stand with support at the age of seven months. At ten months she walked and also looked bright, but her fontanelle remained large. It was noted also that her head circumference, which was 16 inches at the age of eight months, had increased only to 16¼ inches by the time she was one year old. At this time her anterior fontanelle measured 5 cms. along each diagonal, and her skull was assuming a tower shape (a fact that had been obscured by the heavy growth of hair). It was also noted that her palpebral fissures slanted downward and outward.

Roentgen studies revealed synostosis of the lateral portions of the coronal sutures (Figures 4 and 5). Linear craniectomy was performed in May, 1952. There was no sign of any suture in the usual site at operation. The cut surfaces of the artificial sutures were lined with polyethylene film to prevent subsequent union.

The patient's progress in motor, speech, and social behavior has been completely normal since the operation. However, her head circumference is 17½ inches compared to the 19½ inches for the average child of three and one-half years. Her head is still oxycephalic, but recent x-rays reveal no ossification of the artificial sutures.

DISCUSSION

No attempt will be made to discuss this subject in detail, except to point out certain features appearing in our case and to be found in the literature.^{18,19} The term achrobrachycephaly,²⁰ among all the terms found, best suits this case. This refers specifically to those conditions in which the lateral parts of the coronal sutures are closed, but the sagittal suture and fontanelles remain open. As a result the head is broadened laterally, flattened in an anteroposterior diameter, and a tower shape results. Adenoidal facies and lowered external canthi of the eyes, both present in this case, are other unusual features of this condition.

Treatment with linear or mosaic craniectomy offers real hope of relief. This is especially true if performed during the early part of the first year of life when the major portion of brain growth occurs.²¹

Full credit should be given to Drs. R. A. Keddy and S. LaCorte of the Stamford Hospital X-ray Department for the x-ray studies.

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FIGURE 5

Cranial stenosis: This lateral view of the skull clearly shows the complete lack of coronal sutures (lateral portions). The AP measurement is narrow compared to the vertical. Note the extent of the open anterior fontanelle and sagittal suture.

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DYSMENORRHEA AND MENORRHAGIA IN ADOLESCENCE

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A DISCUSSION of dysmenorrhea and menorrhagia as they occur in adolescence can clearly illustrate the physician's need to consider both the physiological and psychological characteristics of the particular age group to which his patient belongs. For that reason a brief review of those features of these two symptoms which we believe of importance in caring for young girls and of how we feel one should think about them and manage them when they occur in adolescence should be of value.

Dysmenorrhea is common. That it is common we know from previous studies of college populations and from a recent survey of high school girls. These surveys show that dysmenorrhea occurs in about thirty-five per cent of girls. It interferes with many girls' daily lives: twenty per cent of a group of 392 high school girls missed school because of cramps one or more times, and five per cent from four to eight times during the school year. But in adolescence it is not the symptom which is of primary importance. It is the cause of those cramps which makes us regard the symptom seriously. If the symptom of incapacitating cramps is an indication that the girl is having a difficult time in adjusting to adolescence and therefore likely to have problems as an adult, it surely deserves our attention. During adolescence is the time to do something: the time to stop and to heed this warning symptom; the time to

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SUMMARY

Dysmenorrhea is a symptom incapacitating to a large percentage of girls. The cause of the dysmenorrhea is of fundamental importance and should be thoroughly investigated during adolescence. Suggested procedures are given for managing these patients.

Menorrhagia, another condition requiring consideration of both the physiological and the psychological characteristics of a particular age group, is briefly discussed and the management illustrated by two case histories.

try to find out what this symptom is trying to say to us.

Only rarely will some organic condition such as a dermoid cyst or inflammation or adhesions be present, but girls who have dysmenorrhea should first have a careful history and physical examination. That does not mean that a pelvic examination should be done; a rectal examination will suffice. These patients are adolescents and though the examination needs to be thorough, it needs just as much to be done thoughtfully.

Dysmenorrhea does not occur until ovulation has begun and therefore a test for pregnandiol might seem to be of little value. However, to do it may help to reassure the patient and her parents that "her glands are all right." Also occasionally it is helpful to give the patient a pain-free period by suppressing ovulation with estrogen. This may capture the patient's cooperation when other methods have failed; and it can serve, in case of doubt, to assure you that the dysmenorrhea is functional. If a course of estrogen produces a pain-free period, organic pathology can be dismissed as a possibility.

A little attention, some aspirin, some edrisal, will be all that many will need. The "little attention" is very important: all these girls deserve not only a careful examination but a chance to learn that you are really interested in them, that you are as interested in them as in their symptom. There are other girls, those whose symptoms arise out of a more serious emotional conflict who will need more help than that. It is in getting to understand these adolescents that most needs to be done and most needs to be learned. How do this adolescent's attitudes and feeling affect her symptom? What is the symptom saying for her? In an amateur's jargon, "What gripes her?" Here is where an understanding of the worries which commonly affect adolescents—not those which affect little children, nor those which affect adults—helps out. Is it worry about school, or confusion about death or about a conflict in her home? Does her poor relationship with her mother make her unwilling to become more feminine? Does menstruation disturb her because it means the end of childhood? Does it gripe her that she isn't a boy? Does she resent being treated like a baby? Is she afraid of the consequences of growing up? Do boys and sex alternately frighten and intrigue her? These are the confusions and vacillations typical of the adolescent. These adolescents are not abnormal, but they do need support, they do need a chance to get these things straight, and they need to do this before they get into the more firmly fixed attitudes of adulthood.

There is nothing mysterious and difficult about all this. These are patients, in most instances, whom any physician interested in young people and willing to give them some time, willing to do much listening and little or no talking, can help. The girl who has severe incapacitating cramps is a girl under tension. To give her only a pill, or to tell her that everyone has cramps, is to lose an opportunity to

help her with the sort of problem that can seriously affect her adjustment as an adult. Not by prying questions, not by a silent stare, but by showing your interest in her, by talking to her about herself and her interests are you likely to find her telling you what it is that got her wound up so tight.

Sandra's menarche occurred at twelve. Her periods were pain free until thirteen when they became so severe that she would go to bed with nausea and severe cramps. Her physical examination revealed nothing of significance except for the impression gained from her appearance; she seemed to be a very good little girl, tense, proper, very plain—the eldest of six children. Her urine assay showed pregnandiol. Given a chance to talk, she complained of her many duties at home and dared to mention her resentment of her lucky brothers. Telling someone who was interested in her about these gripes of hers helped her. Soon she began to dress up a little, then to show an interest in boys. Later when she really became interested in one boy, her dysmenorrhea returned again, only to level off as the conflict of these new feelings with the frightening picture of boys her mother had painted was straightened out. Here is a girl whose symptom fluctuated with the fears and desires that are involved in growing up.

Dysmenorrhea is not a serious ailment, but if we will help the confused feelings that many adolescent girls have, much can be done both to relieve their cramps and also to insure their more satisfactory adjustment to womanhood.

* * * *

Menorrhagia is not common but it demands prompt treatment. The patient and her parents are usually frightened, and keeping in mind how important it is not to let this incident color a young girl's attitude toward sex with fear, one should be even more calm and confident appearing and thoughtful than usual. Calmness and confidence are really justified, for in adolescents menorrhagia is usually physiological; as we explain it to them, the ovaries have not yet learned to do their job with adult efficiency. Menorrhagia can, of course, indicate the presence of some systemic disease—leukemia, tumors, liver disease. A careful physical examination and laboratory tests will uncover these or rule them out. Only rarely will a pelvic examination have to be done; when it is necessary, it should be done under anesthesia.

The chances of menorrhagia in adolescence being

functional are so great, and the allaying of anxiety and further bleeding so important that to wait long for a positive diagnosis is unwise. It is not only permissible, but advisable, in case of doubt, to start treatment with progesterone immediately. Usually 40 mg. of progesterone by mouth for four days will control the bleeding. This treatment, however, will have to be repeated each four weeks thereafter for four days for several months until the patient shows you, by establishing her own adult cycle, that she no longer needs it. When progesterone by mouth does not stop the bleeding it should be given parenterally; and then, if this fails, further search should be made for systemic disease.

Two histories will illustrate some of these points. Jean's story in brief was this. At fourteen she began to have distressing periods with clot formation. She also had intermittent pain in her leg and hip and occasional nosebleeds. Four months after these symptoms began, she was found to have pallor, a liver edge 3 cm. below the midcostal margin, a palpable spleen, a RBC of 1.6 and a WBC of 3.2 with 66 per cent lymphocytes. A diagnosis of acute leukemia was made.

We must think of these diseases but fortunately in adolescents Jean's story is rare and Edith's common. Edith's first period occurred in May, the next in September, both scanty. Then a period began on

December 2 and continued for three weeks when she came to us, a very frightened little girl. Her physical examination and laboratory studies were all negative. She was given 40 mg. progesterone for four days and her bleeding ceased. Progesterone was continued for four day periods each month until she told us, by going on her own schedule, that she was producing enough of her own.

One's manner, prompt attention, calmness, a realization that in adolescence this is usually a functional disorder which will respond to progesterone, and that it is frightening, are the important points. One further thought about these girls' anxiety should be borne in mind for one can be misled especially by the younger girls. It may not be just the bleeding that worries and causes the tears. What it is that worries and upsets a little girl has to be considered. She may be more upset by the fear that the doctor will tell her that she'll have to give up riding or swimming or camp, than she is by the bleeding. If you think of such things and give your patient a chance to talk about them, you can spare her these worries, too. The need to allay these patients' and their mothers' fears and to keep the illness from being a frightening event cannot be overemphasized.

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AN ADDRESS TO THE ENTERING CLASS OF ANY MEDICAL SCHOOL

GEORGE BLUMER, M.D., *San Marino, California*

Fellow Students:

I use this form of salutation advisedly, for any physician who fails to study throughout his career will never reach the acme of his potentialities.* I began the study of medicine just 60 years ago and it would take many ponderous tomes to record the advances in its science and its practice which have been achieved in that time. Medicine moves so swiftly that a medical book is out of date in some matters before it is in print. Doctors, as Francis Galton pointed out, tend, like ministers, to be too positive in their opinions, and you may be quite certain that many statements made to you during your training by even your most careful and meticulously accurate professors will be disproved by the time you graduate. This makes it essential that you should learn to think for yourselves, and it is better to think and sometimes be wrong than never to think at all. Indeed, if there is any one thing which you will need above all in fashioning a successful medical career it is the ability to think clearly. Nowadays medical students must have at least two years of college training, but unfortunately there are still too many colleges that fail to regard ability to think and knowledge of how to tackle problems, not fullbacks, as the most important thing they have to impart. In medicine you must have the facts on which to base your reasons before you can think correctly. Sometimes these are not available and one can then only conjecture or, in plain English, guess.

In the practice of any branch of medicine the fields in which you need the greatest exactitude are diagnosis and prognosis. Rigidly accurate diagnosis is not always essential to successful treatment, but it is always highly desirable, because the more accurate the diagnosis, the more intelligent the treatment is likely to be. There are many well known examples of the discovery of valuable remedies

before the real nature of the disease which they relieved was known. Mercury and arsphenamine helped many patients with syphilis before Schaudinn found the treponema. Quinine (Jesuit's bark) scored many a patient with malaria long before Laveran discovered the plasmodium. Withering based the use of digitalis on an old wife's tale, and it is well not to turn up one's nose at reputed remedies simply because they are not backed by pharmacological evidence and are a matter of folklore. Codliver oil was useful long before vitamins were discovered.

The day has gone by when you will be subjected daily to hours of pants-polishing lectures while seated on hard benches. There is still need for some didactic teaching, but I think perhaps this should be mainly devoted to orienting, for the field of medicine has become so vast that such correlation is necessary. Do not take many notes unless you wish to develop into one of those human parrots that get high marks in examinations but often fall down as practitioners. Confine your notetaking to a few headings. Taking a lot of notes distracts your attention from what your teacher is trying to put over and much of his information can be found in text books and articles anyhow. The main purpose of education, even technical education, is not to develop a good memory for facts except incidentally, but to teach one to think, to critically analyze, to synthesize. Do not swallow whole everything your teachers tell you, question everything critically, learn to form your own opinions on the evidence presented. You will make some mistakes, no physician ever avoids that, but "the man who never makes mistakes never makes anything."

Go to the autopsy room and the clinico-pathological conference to learn humility. Beware of "stuffed shirts," they are mostly inflated with the gas of self esteem. Pomposity and dignity are not

*Man, of course, embraces woman

synonymous terms. The pompous often develop a frame of mind inimical to progress.

Do not begin to specialize too early, for the poorest specialist is usually the one with the least general medical knowledge. It is well to erect any structure, even an educational one, on a broad basis. A century ago there were only a few large centers where one could go for training in the specialties of that day. Most of the specialists of that age went into specialism because their experience in general practice had developed some particular interest or aptitude, and these men usually knew the broad field of general medicine well. Read Charles Reade's "Very Hard Cash" to get a humorous view of what happens to narrow specialists. His character, "Doctor Samson," was founded on a real medical man, a shrewd observer, albeit a bit cynical and not very popular with the official representatives of medicine in his day.

Accept new remedies with caution, especially if they have been "boomed" in the public press. Many will, under the acid test of time, prove valuable additions to our therapeutic armamentarium, but they will always be too uncritically accepted and too indiscriminately used at first, will probably then go through a period of derogation, especially if unpleasant side effects are discovered, but will finally reach their proper therapeutic level, sometimes only after years.

Avoid fads, faddists, and crackpots, they are usually poorly balanced, although even a good doctor may occasionally go off on a tangent concerning some minor matter. One of the most essential characteristics for real success in the practice of medicine is sound judgment and hard common sense, though in all fields brilliancy is no handicap in the well balanced.

Don't get into the habit of thinking of your patients as "cases." They are human beings with all their good and bad qualities. A patient may have smallpox but you must treat the patient primarily and not his disease. The modern conception of

psychosomatic medicine is, on the whole, a sound one, though at present certain aspects of it are being overstressed. Time will take care of that. The recognition of the relation of psychology to disease is older than Hippocrates. Successful physicians have always been psychologists even though they may not have been described under that name. The essential thing to remember is that every patient has both physical and psychic reactions to disease, and that to neglect either, is to fail to visualize the patient as a whole. In most patients your knowledge of psychology need not be very profound. I have frequently been astonished by the results of a single interview if it permitted the patient to get the psychological factors in his case out of his system (mental catharsis). Of course there are a good many difficult problems which need handling by a psychological expert. You must learn to pick out those patients who need special help. Do not attempt to treat them without special psychological training, you may do more harm than good.

Do not forget that our most powerful therapeutic agent is still rest with a capital R, though of recent years it has been recognized that bed rest can be overdone and may encourage the formation of thrombi and at times secondary emboli. Above all don't forget Francis Peabody's dictum: "the secret of the care of the patient is in caring for the patient." He did not mean by this that you must hold the hands of all your women patients, though as Sterne put it "there are worse occupations than feeling a woman's pulse." What Peabody meant was that the true physician has a real feeling of sympathy and understanding for his patients, without which no physician can reach the acme of professional success. I am not speaking of mere financial success which, in a physician, is of itself not success at all. No doubt money is a necessary commodity, and most practitioners of medicine earn a reasonable competence, but a man who enters medicine with the sole idea of getting rich is not a true disciple of Hippocrates—he forgets that medicine is a profession not a trade.

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EDITORIALS

What Is Our Goal?

There are several organizational changes being proposed in the present session of the legislature which concern the health and medical services furnished by the State. In many of the discussions one hears a great deal about the details involved in such changes; very little attention is being given to the underlying principles that are involved. The question of whether the State should be developing a hospital program duplicating the hospital facilities existing in many of the larger communities of the State is lost sight of in the discussion of what State agency should be operating them.

The question has been raised whether our State tuberculosis sanatoria should be set up to admit other chronic diseases. This presumes that we no longer have need for the present number of beds set up in our State institutions.

For the first time in the history of our efforts to conquer tuberculosis we have hopes of having adequate hospital facilities to meet the needs of recognized cases of this disease. Would it be pertinent for the State to consider making a much greater investment of time and effort to search out the many unrecognized cases that are walking the streets? If we did a more intensive and extensive job of case finding, all the hospital facilities designed and developed for the care of tuberculosis would be needed to care for the influx of cases. After many long years of work the techniques of finding tuberculosis have been developed. Is this the time to cut back on

tuberculosis control, when our chances of ultimate conquest of the disease are much better than they have ever been?

The State has for many years assumed a responsibility to provide humane institutions for certain disease categories—tuberculosis and mental disease. Has the State openly assumed the responsibility to establish another humane institutional system to care for chronic diseases?

If we are committing ourselves to provide State hospitals for chronic diseases, are we specifying which chronic diseases? Actually chronic diseases may be almost any disease which persists longer than a certain period of time, depending upon what definition you choose from the many that have been offered. Are we talking about chronic diseases which are catastrophic in nature? Should the State attempt to build a hospital system to care for such catastrophic diseases?

If there is a need to provide a hospital facility for such catastrophic diseases, should the State attempt to duplicate the community hospital systems? Or should the State make grants to the private hospitals so that they can meet these needs? Can such State hospitals attract medical staffs of the same quality as the existing voluntary hospitals? Will such State hospitals for chronic diseases remove people from their usual haunts and established friendships, so that "social fractures" will develop?

Another organizational change being considered is transferring mental hygiene from a health agency

to a hospital agency. The desirability of such a change is more difficult to evaluate in part from general failure to identify terms. The mental hospitals set up to treat mental disease have been brought together in a Department of Mental Health. By adding the name health to an activity whose function is the treatment of diseases introduces a distracting new concept. When we next speak of mental hygiene programs, we introduce another word if not another concept.

Perhaps it would be clearer to everyone if we took over into the field of psychiatry some more familiar words like treatment and prevention. If the State said, "We need to carry on two programs in the field of mental disease—one for treatment and one for prevention," we would all have our bearings. If the State went on further to indicate that they envisaged the treatment program as an institutional program with adequate research and follow-up, it would be still clearer.

The prevention of mental disease is not as clearly understood as is the prevention of many other diseases. If you want to call it mental hygiene, well and good. If you want to call it the teaching of normal behavior patterns or normal living you begin to get into the field of broad health education. The distinction between the prevention of specific psychiatric deviation and the promotion of normal behavior patterns is certainly a twilight decision.

There would seem to be little doubt that such a program would have to be very broad, interwoven with many other health education patterns and difficult to attach to a necessarily limited institutional program. Such considerations raise the specific question: "Should there be clear distinctions made between the State's institutional programs and its non-institutional programs?"

Another problem needing clearer definition is that involving the broad field of rehabilitation. For some time the State has operated a vocational rehabilitation program. There is a growing interest throughout the State and nation in physical rehabilitation. If the State embarks on a physical rehabilitation program, should this be coordinated with vocational rehabilitation or should vocational rehabilitation become a part of an overall agency combining the many phases of physical rehabilitation together with vocational rehabilitation?

The first question to be answered, it would seem,

would be whether the State should assume the responsibility of establishing a physical rehabilitation program. After that has been decided it would seem logical to proceed with the more specific details of administration patterns, whether they are institutional or noninstitutional programs, whether they are predominantly medical or nonmedical.

It seems that the State would develop health and medical services suited to its needs and economic resources if it established basic principles before proceeding with administrative patterns.

The Acute Abdomen

In this issue Philip Thorek of Chicago presents a thumbnail sketch of the principal etiological factors in the acute abdomen. Because he has found that seven conditions account for around 90 per cent of the pathological conditions constituting such emergencies, he omits from his discussion an host of other conditions which may be encountered. One among these which is apt to catch the unwary surgeon is bleeding from a ruptured corpus luteum. Only rarely is this of such proportions as to require laparotomy.

Ever since the entity of acute appendicitis was recognized and surgical interference encouraged just prior to the beginning of this century, its signs and symptoms have bedevilled and deceived the general practitioner and surgeon alike, until today most surgeons believe it wiser to open the abdomen if there is any question of the presence of an inflamed appendix, even though the diagnosis may be found to be erroneous.

Dr. Thorek points out the fallacy of looking for right rectus rigidity in the presence of an acute appendix before a mass has developed. He calls attention to the extremely valuable method of examination with one finger in the vagina and one in the rectum whenever possible.

The apparent increase in coronary disease has contributed to a situation one would not have encountered a few years ago, viz., the inclusion of coronary disease under the heading of acute abdominal emergencies. The experienced surgeon needs no warning of the serious consequences which follow opening an abdomen in the presence of an acute coronary attack. If his confrere, the general practitioner, or even the experienced internist has overlooked such a diagnostic possibility, he must not let his diagnostic acumen lapse for a moment.

You Have Cancer

The question of whether to inform a patient with cancer of his condition or to keep the truth from him continues to be debated. Conflicting opinions have been derived from questionnaires sent to physicians. For example, in Philadelphia replies to a recent questionnaire received from eight groups of physicians, including surgeons, internists, general practitioners and the common specialties, stated that only 31 per cent usually or always tell the patient. On the other hand, Wisconsin surgeons were queried and in 108 return from 118 questionnaires 65 per cent answered "yes" or "usually."

In defending the premise that a patient with cancer should be told, one of Wisconsin's surgeons* has called attention very fittingly to the change which has come about in our ideas, mode of practice, and knowledge of medicine during the past half century. When the diagnosis of cancer was made at the turn of the century the situation was usually hopeless and the patient doomed. The disease was looked upon as a disgrace to the family and everything possible was done to hush up any information that might possibly leak out—including telling the patient the truth. Now we have an informed public to deal with, methods of making an early diagnosis if given the opportunity, and with the advance in the use of surgery, irradiation with x-ray and radium, and the use of minerals and chemicals, a greatly enlarged therapeutic armamentarium is available.

There are two arguments for telling the patient with cancer the truth. A patient selects a particular physician because he has confidence in him and trusts him. If in return the physician withholds the truth after the diagnosis has been established, what effect does that have on that trust which the patient has placed? One often hears the excuse made that a patient cannot stand the shock of knowing the diagnosis. It is indeed a rare individual who cannot receive the true diagnosis.

To be told that one has cancer challenges the very depth of one's spiritual reserves. It affords a time for soul searching and, if we believe in a life hereafter, a time for preparation. There comes no moment of greater satisfaction in a physician's life than that occasion when, as the curtain seems to be closing down on the future of one who has intrusted his life to the professional human skill of the doctor,

he can bring to the patient a sense of peace, and a comforting trust together with no fear of the future.

The Hospital Chaplain

The idea of an hospital chaplain first found root in 1924 when Rev. Anton T. Boisen, a Congregational clergyman and graduate of Union Theological Seminary, was appointed chaplain of the Worcester (Massachusetts) State Hospital. In addition to his prescribed theological training Dr. Boisen studied at Harvard University and Andover Theological Seminary and had some practical experience in psychology and social service. His eight years of service in the Worcester institution was a unique demonstration of the value of trained religious ministry to the mentally ill. From this small beginning there has developed an incorporated Council for the Clinical Training of Theological Students until today mental hospitals, general hospitals, and penal and correctional institutions have been served by over one thousand men and women enrolled in or graduates of theological schools in the United States and Canada. Connecticut now has full time Protestant chaplains at the State Prison in Wethersfield and at the State Hospitals in Norwich and Middletown.

There appears to be a growing need for chaplains in general hospitals, particularly in the larger ones. There are patients who come from some distance and feel lonely. There are others who face major surgical procedures and need a hopeful reassurance. Some need an outlet of expression for their emotions and others are finding adjustments following major surgery difficult. There is a group of patients who have never had any awareness of personal religion and for the first time feel a need for it.

The hospital chaplain ministers not only to the patient but also to the nurses. Many hospitals with chaplaincy departments are opening their doors to theological interns who can acquire a knowledge of hospital life which is invaluable to them in their future pastorates. Seminars for physicians and clergymen such as have been held at the Hartford Hospital serve to remind the physician of the religious needs of the patient and the clergyman of the effect the physical condition often has on a patient's religious attitude.

To summarize the value of the hospital chaplain plan: "While the hospital experience may not con-

*Wisconsin Medical Journal, October 1954, 53:10.

stitute a great personal crisis for every patient, yet it provides opportunity for people to do more contemplating than is usual. If hospital patients do more serious thinking than people on the outside, it seems logical that, wherever possible, wholesome direction for such thinking ought to be given patients who indicate willingness to accept it. The professional hospital chaplain seems to offer the best solution to this problem.”*

Regulations For Distribution and Use of Polio Vaccine

The first meeting of the Poliomyelitis Vaccine Advisory Committee, appointed by Governor Ribicoff under the provisions of House Bill 1984, Connecticut General Assembly, 1955, was held on Thursday, May 5, 1955 in the office of the Commissioner of Health. Its entire membership was present, consisting of the following: Oliver L. Stringfield, M.D., president, Connecticut State Medical Society, Stamford; Alfred L. Burgdorf, M.D., director of health, Hartford; Mr. Benjamin Smith, president, Connecticut Pharmaceutical Association, New Haven; Mr. Frederick S. Fried, vice president, Sisson Drug Co., Hartford; Bruce R. Valentine, M.D., director of health, Chaplin, Eastford, Hampton and Abington; Stanley H. Osborn, M.D., State Commissioner of Health, Hartford.

Dr. Stringfield was elected chairman of the Committee, and Mr. Fried, secretary.

Proposed regulations on Priority of Supply, Distribution and Use of Poliomyelitis Vaccine were discussed in accordance with the provisions of House Bill 1984, for submission to the Public Health Council, and it was unanimously voted that these regulations, copy attached, be approved and recommended to the Public Health Council. It was voted also that such regulations be of temporary nature so that they can be revised without delay from time to time as the vaccination program stabilizes and the vaccine becomes available in sufficient amounts to spread the priorities with respect to age groups.

These regulations were adopted by the Public Health Council at a special meeting held on Friday, May 6, were filed with the Secretary of State on Monday, May 9, and become effective on May 9.

*Rev. G. Westberg, Bull. of Maternal Welfare, March-April, 1954.

PRIORITY OF SUPPLY, DISTRIBUTION AND USE OF POLIOMYELITIS VACCINE

As recommended by the Polio Vaccine Advisory Committee at its meeting on May 5, 1955.

REGULATION 181-6-1. SUPPLY AND DISTRIBUTION

(a) No poliomyelitis vaccine shipped into the State of Connecticut shall be exported or transferred out of State except on approval in writing obtained from the Commissioner of Health.

(b) The Commissioner of Health may embargo any lot, shipment or portion of poliomyelitis vaccine for reasons of questionable purity, potency and safety.

(c) The Commissioner of Health may require any wholesale or retail pharmacist, or distributor with a supply of poliomyelitis vaccine to release through established trade channels any or all of his supply for transfer to other areas within the State where the Commissioner of Health deems the immediate need to require such action.

(d) Sale or transfer of poliomyelitis vaccine to the public is prohibited.

(e) The 1955 program of the National Foundation for Infantile Paralysis is exempted from these regulations.

REGULATION 181-6-2. PRIORITIES AND USE

(a) Effective May 9, 1955: Poliomyelitis vaccine shall be administered only to children five years of age to nine years of age, inclusive. Any course of vaccination begun before May 9, 1955 may be completed.

(b) When any physician shall have reasonable doubt as to the age eligibility of a prospective vaccine recipient, he shall require that person to produce for his inspection a satisfactory record or document establishing the age or date of birth.

REGULATION 181-6-3. RECORDS

(a) Each person licensed to practice medicine and surgery, for himself or for a clinic, hospital, institution, government or voluntary agency shall keep a record of poliomyelitis vaccine received by him, itemizing the date, manufacturer, lot number, amount, nature of packaging and source of this vaccine. For poliomyelitis vaccine administered, he shall similarly record the name, address, sex and age of the patient, and site of injection, the nature of the injection (first, second or booster dose) and the manufacturer and lot number of the vaccine used.

(b) Each wholesale or retail pharmacist, or dis-

tributor, shall keep records of all poliomyelitis vaccine received, sold or transferred by him, and shall on the last business day of each week take an inventory of current supply. For vaccine received this record shall include date received, manufacturer, lot number, quantity and source; for vaccine distributed it shall include date distributed, manufacturer, lot number, quantity and to whom distributed. Shipments made directly from manufacturer to physicians and invoiced to the pharmacist or distributor shall be accounted for in the report required by Regulation 181-6-3 (c).

(c) On forms provided by or obtainable from the State Department of Health, each wholesale or retail pharmacist or distributor shall through a responsible employee report weekly all poliomyelitis vaccine received, sold, transferred, or invoiced, and the weekly inventory of vaccine. These reports are to be sent to the State Department of Health, 165 Capitol Avenue, Hartford 15, Connecticut, each Monday following the calendar week concerned.

(d) Records shall be preserved for a period of one year from the date of the transaction recorded. Such records are confidential and are required to be open for inspection only to authorized employees of the State or the local director of health.

(e) Any poliomyelitis vaccine destroyed, missing or stolen shall be reported immediately to the State Department of Health.

The section numbers indicate the official numbers to appear in Connecticut Departmental Regulations.

AUTHORIZATION FOR REGULATIONS

HOUSE BILL NO. 1984: AN ACT CONCERNING
POLIOMYELITIS VACCINE

Governor approved April 28, 1955.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. The governor shall appoint a poliomyelitis vaccine advisory committee, consisting of the commissioner of health and such five other persons as the governor deems advisable. The committee shall recommend to the State Department of Health the priority of the supply, distribution and use of poliomyelitis vaccine in the interest of the health, welfare and safety of the people of the State. The State Department of Health, after receiving such recommendations of the committee, is authorized to make regulations determining the priority of supply, distribution and use of such vaccine, considering the age or physical condition of the persons most susceptible to poliomyelitis. Violation of any regu-

lation on the part of physicians or pharmacists made under this section shall be cause for the revocation, suspension or annulment of a license or certificate of registration or other disciplinary action in accordance with sections 4358 and 4472 of the general statutes.

Section 2. Section 3832 of the general statutes is repealed and the following is substituted in lieu thereof: Said department is authorized to procure diphtheria antitoxin, tetanus antitoxin, vaccine lymph, poliomyelitis vaccine or other biologic products for the free use of people of the State upon whom the purchase thereof would impose a financial hardship, and to distribute the same to town, city and borough directors of health who shall furnish the same to such persons upon recommendation of attending physicians, provided poliomyelitis vaccine shall be distributed in accordance with priorities established under section 1 of this act.

Section 3. The biological products purchased by the appropriation provided by number 55 of the special acts of 1955 shall be distributed in accordance with section 2 of this act.

Section 4. If the State Department of Health finds that there is an epidemic of any disease within the State and that antitoxin or other biologic product is in short supply, the commissioner shall notify the governor, who may proclaim that an emergency exists. On such declaration the State Department of Health is authorized to make regulations as specified in section 1 hereof, determining the priority of the supply, distribution and use of such biologic product.

Section 5. This act shall take effect from its passage.

SPECIAL ACT NO. 55: AN ACT MAKING AN APPROPRIATION
TO THE STATE DEPARTMENT OF HEALTH FOR
POLIOMYELITIS VACCINE

Governor approved April 7, 1955.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. The sum of one hundred thousand dollars is appropriated to the State Department of Health for the purchase and distribution of poliomyelitis vaccine licensed by the National Institutes of Health, United States Public Health Service, in the manner provided in section 3882 of the general statutes.

Section 2. The money appropriated under the provisions of section 1 of this act shall be payable immediately on passage of this act.

PROGRESS IN CLINICAL MEDICINE

THE CHEMOTHERAPY OF NEOPLASTIC DISEASE

HENRY M. WILLIAMS, M.D., *Hartford*

THE present discussion is concerned with a review of the principal chemotherapeutic agents available for control of disseminated inoperable cancer. The neoplasms now amenable to chemotherapy are (a) the lymphomas and leukemias, and (b) far advanced carcinoma of the breast or prostate which is progressing in spite of adequate surgical and x-ray therapy. At present chemotherapy affords only temporary control of these neoplastic diseases, but in the future perhaps the effectiveness of medical management may be extended for longer periods of time and to include other malignancies. Damashek¹ recently expressed this hopeful perspective as follows: ". . . if the proliferation can be stopped for a few months, perhaps it can be stopped for a few years; if it can be stopped for a few years, perhaps it can be stopped for a number of years. Thus, conceivably, one might in the end be left with a disease that was perhaps not curable but controllable; it would matter little whether the disease was cured, so long as the patient remained clinically in good health."

THE LYMPHOMAS AND LEUKEMIAS

1. Radiomimetic agents.

(a) Nitrogen mustard (HN₂), which is most effective in the management of Hodgkin's disease, has an histological effect on tumor cells similar to x-ray. Its use is indicated in the following situations:^{2,3} (1) after the disease is generalized; (2) for the relief of toxic symptoms such as fever, weight loss, pruritis, fatigue and anemia; (3) for radioreistant disease; (4) and to precede x-ray therapy in spinal cord lesions and the superior vena cava syndrome to obviate the initial edema caused by radiotherapy. HN₂ is less effective but of some benefit in chronic lymphocytic leukemia, lymphosarcoma and reticulum cell sarcoma.

The agent is administered intravenously in a dose of 0.4 mg. per Kg. of body weight, often in one dose, or otherwise divided into two courses. Nausea

The Author. *Assistant Resident in Medicine, Hartford Hospital*

SUMMARY

The various chemotherapeutic agents currently employed in the management of the lymphomas and leukemias are discussed, with emphasis on indications for use and important side effects of these drugs. Then the role of hormonal therapy in the palliation of advanced breast and prostatic carcinoma is outlined, including some consideration of mechanism of action, as well as the practical aspects of administration.

lasting a few hours appears in 80 per cent of cases within two to twelve hours and is often well controlled by premedication with an anti-emetic agent. Extravasation of HN₂ may result in painful local ulceration or induration. Bone marrow depression usually occurs; the maximum leukopenia is most often noted 10 to 20 days following treatment, and bone marrow recovery ensues in four to six weeks. Uric acid precipitation in the urine is an occasional complication of nitrogen mustard therapy that is secondary to the cytotoxic action of the agent resulting in the breakdown of nucleoproteins with release of purines which are oxidized to uric acid. In an acid urine the latter may precipitate, forming renal calculi and causing ureteral obstruction.⁴ Alkalinization of the urine by previous administration of sodium bicarbonate is suggested as prophylaxis against this complication.

Nitrogen mustard therapy results in rapid detoxification and striking regression of enlarged lymph nodes, spleen and liver. Six weeks is the average duration of a remission but these tend to be shorter and less complete with subsequent courses of HN₂.

(b) Triethylene melamine (TEM) is a radiomimetic agent having the advantage of oral administration.^{3,5,6} Since the lymphocyte is particularly

susceptible to this compound, it is therefore of greatest value in the management of Hodgkin's disease, lymphosarcoma and chronic lymphatic leukemia.¹

The dose varies considerably, but in general ranges from 2.5 to 5.0 mg. (or up to 25 mg.) per week by mouth until maximum improvement is attained or mild leukopenia or thrombocytopenia develops. At this point the patient is placed on maintenance therapy (about 2.5 mg. every 10 to 15 days). Toxic effects include sloughing of the intestinal mucosa and hyperuricemia; nausea develops in only 50 per cent of cases. Leukopenia is usually most pronounced 7 to 14 days after the ingestion of the dose, and the white count, which should be carefully followed, is used as a guide to regulation of dosage.

The results of TEM therapy in chronic lymphatic leukemia and lymphosarcoma are quite encouraging. About 60 per cent of cases may have a remission, which on maintenance therapy may last 10 to 18 months. The results in Hodgkin's disease are variable, but many 30 day remissions are reported.

2. Antimetabolites.

(a) Folic acid antagonists^{2,3} probably act by interfering with the synthesis of nucleic acids in the tumor cells. These agents are indicated in the management of the acute leukemias of childhood, youth and early adulthood. In adults over thirty years of age, however, the toxic effects are so noticeable and the beneficial effects so uncommon, that their use is probably not indicated in that group.

In the management of acute lymphoblastic leukemia, ACTH or cortisone is used prior to, or combined with the folic acid antagonists. This dual therapy appears to have several effects:¹ (1) it increases the chances for a remission; (2) it reduces the toxic reactions to the folic acid antagonists; (3) it decreases the bleeding tendency common in acute leukemia, especially with aminopterin therapy; (4) and it results in a myelostimulating effect when bone marrow aplasia has been induced by aminopterin. It is suggested, however, that ACTH or cortisone are contraindicated in the myeloblastic and monoblastic leukemias, as experience has shown that these patients are either not improved or are actually worse with the additional steroid therapy.⁷

The dosage depends on the particular agent used, (aminopterin, A-methopterin and amino-an-fol are most commonly employed) and is usually carried

to the point of clinical and hematologic remission. The patient is then maintained on ACTH or cortisone, plus small doses or short courses of the folic acid antagonist. Fifty per cent or more of cases obtain complete remissions which may be maintained for periods of four weeks up to two years. Toxicity includes nausea, vomiting, diarrhea, alopecia, mucosal ulcerations of the oral and gastrointestinal mucous membranes, granulocytopenia and aplasia of the bone marrow.

(b) Adenine antagonists² act by interfering with purine metabolism, thereby blocking nucleic acid synthesis in neoplastic cells. Purinethol (6-mercaptopurine) is an adenine antagonist which is effective in the management of the acute leukemias. Patients who have become refractory to the folic acid antagonists may have a second remission on Purinethol, which is therefore a valuable addition to the treatment of those individuals. Toxicity is considered to be less than that observed with the folic acid antagonists, and is manifested principally by leukopenia. The average daily dose is 2.5 mg. per Kg. of body weight, and continued administration is necessary to keep patients in remission; resistance to the drug usually develops in 3 to 4 months.

3. Agents acting by inhibiting or damaging cellular function.

(a) Urethane³ is of some value in the management of chronic granulocytic leukemia and multiple myeloma. It is given by mouth in doses of 1 to 3 Gm. daily, usually for about a month, after which the patient is maintained on 0.5-1.0 Gm. daily. Continued administration is necessary to keep patients in remission. Toxic effects include nausea, bone marrow depression, and liver cell damage.

(b) Myleran^{1,2} is replacing urethane in the treatment of chronic granulocytic leukemia. Since this agent depresses myelopoiesis, probably only those cases with a high white count should be treated with myleran. It is given orally in doses of 4 mg. daily until maximum hematologic improvement is obtained. Remissions have varied from 6 to 21 months.

4. Hormones—ACTH and cortisone.

The use of these agents in acute lymphoblastic leukemia has already been discussed. Occasionally steroid therapy will also result in striking remission in multiple myeloma, but this is by no means constant.

CARCINOMA OF THE BREAST

1. Following castration, great subjective and ob-

jective improvement in patients with far advanced breast cancer is often noted.⁸ It is quite likely that this favorable response results from reduction of circulating estrogenic substances which presumably have had a supporting or stimulating effect on the tumor cells, which may therefore be considered to be estrogen dependent for their growth. Since irradiation often produces only temporary or incomplete suppression of ovarian function, surgical castration is preferable. Eventual relapses are explained by the estrogenic activity of the adrenals, and indeed, some postcastration relapses in estrogen-dependent tumors will respond favorably to adrenalectomy. Hypophysectomy is also being explored as a means of completely suppressing adrenal function.

Some rather interesting observations have been made on the relation of the estrogen dependence of the tumor and calcium excretion in the urine.⁹ In a series of premenopausal women with advanced breast cancer and osseous metastases, an increased urinary calcium excretion was noted. During the menstrual cycle, as the circulating estrogen levels increased, so also did the urinary calcium excretion rise, but only in those patients whose tumors were shown to be estrogen-dependent (by subsequent favorable response to castration). In those patients whose breast cancers were not estrogen-dependent there was no rise in urinary calcium as the blood estrogen levels rose. Since there is no histological difference between the two types of tumors, this may well prove to be a practical method of determining estrogen dependence of the tumor.

Castration is indicated, then, in premenopausal women with estrogen-dependent tumors who have advanced primary, recurrent or distant metastatic breast cancer. About 60 per cent of cases will feel better subjectively, and 25 per cent will show regression of bony metastases; this improvement may be maintained for a period of eight months to two years.¹⁰ Castration also results in regression of advanced male breast carcinoma, but as yet there are insufficient case reports to permit statistical analysis.

2. Androgens are also employed in the management of advanced breast cancer, and it is likely that this therapy has a dual mechanism of action. First, their administration results in inhibition of pituitary gonadotrophic activity which in turn leads to suppression of ovarian and adrenal activity, thereby reducing circulating estrogens by a "medical" castration.⁸ It is also suggested that stimulation of fibroblastic activity and osteogenesis by androgen

therapy results in a "choking" of cancer cells by fibroblasts in soft tissue metastases, and a "snowing under" of osseous metastases by deposition of calcium around the cancer cells.¹¹

Therefore androgenic therapy may be used in the management of estrogen-dependent tumors; age and menopausal status are not factors in the effectiveness of therapy. Dosage is in the range of 150-300 mg. of testosterone propionate weekly (or the equivalent of an alternate preparation), given in three divided doses, usually until a total of 3 Gm. has been given; the patient may then be maintained on 60 mg. of methyl testosterone daily. Masculinizing effects and sodium retention are commonly encountered. An interesting side-effect is the hypercalcemic syndrome (nausea, vomiting, atonicity, apathy and in severe cases, coma), which occurs spontaneously in 10 per cent of untreated cases and in a higher percentage of those receiving androgen therapy. Four possible causes have been advanced to explain the hypercalcemia: (1) androgen therapy results in the repair of bone lesions, and as the necrotic bone is replaced, calcium is liberated into the blood stream; (2) immobilization of debilitated patients results in bone resorption and hypercalcemia; (3) pre-existing renal disease; (4) the positive calcium balance induced by steroid therapy may also add to the elevated blood calcium.

Androgen therapy results in subjective improvement in about 75 per cent of patients and approximately 25 per cent may show regression of bony metastases. Twenty per cent of patients may maintain this improvement for periods of nine months to two years.

3. It seems paradoxical that, on the one hand, estrogens will accelerate the growth of estrogen-dependent tumors, while in other instances their administration will be effective in the management of certain breast cancers.^{8,10} However, it is suggested that administration of estrogens in high doses results in the inhibition of the pituitary gonadotrophic effect, which may play a role in stimulating the carcinoma. Also, like androgens, estrogens induce fibrosis, calcification and osteogenesis which may result in "choking" of the carcinoma cells in soft tissue and bone.

The use of estrogens is restricted to those patients whose tumors are nonestrogen dependent, and who are five years or more beyond the menopause. Dosage is in the range of 15 mg. of stilbestrol daily by mouth. On this regimen about half of properly

selected cases will show both subjective and objective improvement. Estrogen therapy is less effective than androgens on bony metastases, and objective improvement is most noticeable in soft tissue lesions. About 25 per cent of cases will maintain their improvement for nine months or more. Inasmuch as abrupt withdrawal of estrogens may lead to significant menorrhagia, cessation of therapy should be gradual.

4. ACTH and cortisone have been reported to result in temporary clinical improvement and decreased urinary calcium excretion in some nonestrogen dependent tumors.⁹ However, at this time only a few cases managed in this fashion have been reported.

CARCINOMA OF THE PROSTATE GLAND

Castration and/or estrogen therapy often result in great improvement of advanced prostatic cancer.^{8,10} It is felt that in its early stages, at least, prostatic cancer is androgen dependent, and therefore castration induces improvement by decreasing the level of circulating androgen. Estrogens, on the other hand, probably act by inhibition of the pituitary gonadotropins, thereby decreasing the production of testicular and adrenal androgens. It has also been suggested that estrogens have some neutralizing effect on circulating androgens.

Relapses are explained on two bases: (1) the tumor has become nonandrogen dependent; (2) because of the fall in circulating androgens there is increased pituitary gonadotropic activity which results in increased production of androgens by the adrenals. In any event, hormonal therapy of some type is probably indicated in inoperable prostatic carcinoma, and in addition there is evidence that pretreatment with estrogens will render some previously inoperable tumors amenable to surgery. Although there is no general agreement as to whether castration or estrogen therapy should be used alone or in combination, there are some indications that estrogen therapy alone may be less effective than castration alone or combined castration and estrogen therapy. Dosage of stilbestrol ranges from 1 mg. to 15 mg. per day for an indefinite period according to different authors. If stilbestrol is ineffective, TACE may be of benefit.

Results of hormone therapy are difficult to evaluate, but about 75 per cent of cases will experience subjective improvement and 50 per cent will manifest objective improvement in the primary tumor

and metastatic lesions. At least half of the cases maintain their improvement for a minimum of one year, and of course many are managed successfully for longer periods of time.

Progesterone has also been used with some success in a few cases of carcinoma of the prostate on the grounds that there will result decreased production of luteinizing hormone from the pituitary, and thereby less androgenic activity from the adrenals and testes.

CONCLUSIONS

1. Properly selected chemotherapy of the lymphomas and leukemias may result in complete remissions for significant periods of time.
2. Advanced primary, recurrent or distant metastatic breast cancer may show significant temporary benefit from appropriate hormonal therapy.
3. Similarly, advanced prostatic carcinoma may benefit from castration and/or estrogen therapy.

The author is indebted to Dr. N. William Wawro for his helpful suggestions in the preparation of this article.

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THE PRESIDENT'S PAGE

THE REAL BEGINNING

IN the "Roaring Twenties" your State Medical Society proceeded on its own momentum, guided by a few dedicated members, the most prominent of whom was D. Chester Brown, trustee of the AMA. The rest of us followed like a bunch of sheep, spending our time delivering babies in homes, treating diphtheria, scarlet fever, severe whooping cough, small pox, pneumonia, etc. We happily paid our \$3 dues and "let George do it." Income taxes were small and any extra cash we had was used to purchase stocks on a margin. We were self contained and did not think of organized medicine in its broad sense. Then it happened; the bubble burst in 1929. Shortly thereafter we began to hear and feel the rumbles of Medical Economics.

In the early Thirties, Hartford, New Haven and Fairfield County Medical Associations appointed Medical Economics Committees, at the instigation of a bunch of young upstarts. From their studies and exchange of ideas it was soon apparent we could make no progress in the State without a statewide bulletin or medical journal, associated with a reorganization of the office of the Society.

At the meeting of the House of Delegates, 1935, a resolution was passed that the president appoint a Special Committee, known as the Committee from the State Medical Society to Inquire into the Administration of the Office of Secretary. As a result of its recommendations, a complete reorganization of our Society began in 1936 and the quarterly JOURNAL OF THE CONNECTICUT STATE MEDICAL SOCIETY issued its first edition in August. It is fitting that the first four words of the first article of the first issue are: "Dr. Thomas P. Murdock." His clear thinking and unselfishness has contributed more to Connecticut medicine than any one man in its history. Incidentally, he was our president at that time.

The House of Delegates established three secretarial offices. The Administrative Secretary, salary \$600 yearly; Legislative Secretary, salary \$250 yearly; and Secretary on Scientific work, whose duties shall be "to edit, publish and distribute the Quarterly Journal." For this an honorarium of \$300 was paid the Secretary on Scientific Work. Our dues were raised to \$4.

In May, 1937 the House of Delegates authorized our JOURNAL to be published monthly beginning January 1938. By 1940 our editor had done wonders with our JOURNAL. Its format, quality and timeliness of articles, and other information, placed it among the leading state medical journals.

All activities of the Society were greatly stimulated by the enthusiasm and leadership of our part-time administrative secretary. In 1938, for the first time in 145 years existence, our Society established its own office at 258 Church Street with one stenographer.

In two years' time, what advanced changes in our Society! It might be said, for the record, that our reorganization actually began in 1938 and was completed on February 1, 1940, when our part-time administrative secretary began operations on a full time basis. We had arrived.

Oliver L. Stringfield, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

JAMES G. BURCH
Director of Public Relations

JOSEPHINE P. LINDQUIST
Administrative Assistant

160 ST. RONAN STREET, NEW HAVEN

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Annual Meeting of the Council

Dr. C. Louis Fincke, Stamford, elected Chairman.

The Annual Meeting of the Council was held at the offices of the Society on May 12, 1955 and called to order by the President, Dr. Stringfield, at 4:00 P. M. Dr. Stringfield asked that the members of the Council present stand in tribute to Dr. Thomas P. Murdock and ask divine guidance for the coming year. There were present in addition to Dr. Stringfield, Drs. Ogden, Couch, Barker, Danaher, Gibson, Feeney, Fincke, Gallivan, Ursone, Tracy, Russell, Archambault, Ottenheimer, Gens, Clarke, Meyers, Buckley, Dwyer, Gilman. Absent: Drs. Weld, Murdock, Marvin, Flaherty, Starr.

Nominations for Chairman of the Council were called and Dr. Ursone, Councilor from Litchfield County nominated C. Louis Fincke, Stamford, Councilor from Fairfield County. The nomination was seconded by several and it was moved that the nominations be closed and the secretary cast one unanimous ballot for Dr. Fincke.

Dr. Fincke assumed the chair and introduced Ralph T. Ogden, president-elect and later introduced Royal A. Meyers, alternate councilor from Litchfield County. Richard M. Starr, alternate councilor from New London County was unavoidably absent.

Resignations and withdrawals from committee appointments were noted as follows and replacements made:

John W. Buckley, from the Committee on Public Health and Committee to Study Neonatal Mortality. Replacement was postponed for further advice from the president after counsel with pediatricians in the State.

Martin I. Hall from the Conference Committee with the Pharmaceutical Association. Fritz M. Meyer, Bridgeport, was appointed to this vacancy.

Kenneth K. Kinney from the Committee on Hospitals. William A. Goodrich, Hartford was named as a replacement.

John C. Larkin, New Britain to be a member of the Committee on Emergency Medical Service.

Stanley B. Weld to be a member of the Committee to Study Maternal Mortality and Morbidity.

It was reported that Edward J. Ottenheimer, surgeon; Benjamin V. White, internist; and Edward R. Howe, obstetrician, had been elected members of the Professional Policy of CMS by balloting by the participating physicians as authorized in the newly revised By-Laws of CMS. Dr. Danaher, chairman of the Professional Policy Committee discussed details of the balloting and reported the nominations of other physicians who had been nominated.

It was announced that the president had appointed a Committee to inquire into the expansion of the Society's building as authorized by the House of Delegates on April 26, 1955. Committee is as follows: Chairman Carl E. Johnson, Frank H. Couch and William H. Horton.

On advice of legal counsel, the Council unanimously passed the following resolution relating to the proposed pension plan for employees of the Society:

"Voted: That the 'Pension Plan of the Connecticut State Medical Society,' as submitted to this meeting in the Statement and Promulgation of said Pension Plan and in the proposed Trust Agreement forming a part of said Plan, be and it is hereby tentatively adopted and approved, with such changes therein as the officers of the Society, with the advice of counsel, may determine to be necessary in order to obtain the approval of said Plan by the United States Treasury Department."

Implementation of the amended report of the Committee on Hospitals approved by the House of Delegates on April 26, 1955 was discussed at length.

Dr. Gallivan presented a carefully prepared memorandum concerning legal decisions relative to the Corporate Practice of Medicine in many States and moved that a special committee from the Council be appointed to inquire further into the subject and make recommendations for carrying out the objectives in the report that was approved by the House of Delegates.

This motion received two amendments: (1) that the committee be appointed by the Chairman of the Council and it consist of not less than three nor more than five members, and (2) that Ralph T. Ogden be a member of the committee and it present its preliminary report to the June meeting of the Council. This amended motion was discussed by many and passed. It was agreed that the report of this committee and the conclusions of the Council need not be referred again to the House of Delegates.

Following the meeting the chairman appointed this committee: Chairman, John N. Gallivan, John P. Gens, H. M. Marvin, Ralph T. Ogden and F. Erwin Tracy.

A resolution relative to the creation of a Loan Fund for Interns and Residents passed by the House of Delegates on April 26, 1955 was discussed. It was voted that the Chairman of the Council appoint a special committee from the Council consisting of three members to make further inquiry into this proposal and report to the Council at an early date.

Following the meeting the chairman appointed the following Committee: to be Chairman, C. Louis Fincke, Frank H. Couch and Edward J. Ottenheimer.

Action of the House of Delegates on April 26 relating to the nomination or appointment of members of the Council to standing and special committees of the Society was presented by the executive secretary for the purpose of clarification.

After brief discussion it was agreed that it was the intent of the House of Delegates in accepting the report of the reference committee of which I. S. Otis was chairman to adhere closely to the recommendations contained in the Bishop Report which was approved by the House of Delegates in 1948 and reaffirm the recommendations in that report to the effect that members of the Council are not to be nominated or appointed as chairmen of standing or special committees of the Society, and that members of the Council will not constitute a majority of the membership of any standing or special committee.

Cole B. Gibson, secretary of the New Haven County Medical Association, presented an invitation from that association for the Society to hold its Annual Meeting in 1956 in New Haven County. This was unanimously accepted with appreciation and Dr. Gibson stated that the county committee on arrangements would be nominated at an early date so that planning for the meeting might begin.

Dr. Danaher called the attention of the Council to the reprimand imposed by the Connecticut Medical Examining Board on Paul P. Duzmati, Bridgeport for fraudulent practices in connection with claims filed with Connecticut Medical Service. The reprimand was published commencing on page 431 of the May issue of the CONNECTICUT STATE MEDICAL JOURNAL. The question was raised as to whether Dr. Duzmati was to be continued as a member of CMS and Dr. Danaher stated that the question had not yet been considered by the Professional Policy Committee.

Dr. Danaher proposed that appropriate amendment to the By-Laws be prepared that would make past presidents life members of the House of Delegates without voting privileges. The chairman and the secretary were directed to prepare such an amendment.

Six student members were elected:

Beverly A. Billinger, Norwalk
Cornell University Medical College—Class of 1958

Pre-Med: Cornell University
Parent: Ben B. Billinger

Frank E. Dully, Jr., West Hartford
Georgetown University School of Medicine—
Class of 1958

Pre-Med: Holy Cross College
Parent: Frank E. Dully

Anthony E. Giangrasso, Trumbull
Creighton Medical School—Class of 1958
Pre-Med: Fairfield University
Parent: Thomas C. Giangrasso

Joel M. Kennedy, Manchester
Dartmouth Medical College—Class of 1958
Pre-Med: Dartmouth College
Parent: Max Kennedy

Jules R. Schwaber, Westport
Cornell University Medical College—Class of 1958
Pre-Med: Wesleyan University
Parent: David Schwaber

Frederick W. Van Duyne, III, Riverside
Cornell University Medical College—Class of
1958
Pre-Med: Cornell University
Parent: Frederick W. Van Duyne, Jr.

Following the meeting, the chairman in conference with the executive secretary set Thursday, June 23, as a tentative date for the next meeting of the Council.

The meeting adjourned at 6:00 P. M.

ANNUAL MEETING ATTENDANCE

Although the attendance at the 163rd Annual Meeting of the Society in Stratford on April 26, 27 and 28 was not quite as large as the meeting in Hartford in 1954 it was received enthusiastically. The program was one of exceptional merit and the Secretary's Office wishes to compliment the local committee on arrangements of which Edwin R. Connors was chairman and the program committee under the direction of Samuel D. Kushlan. 854 physicians registered, 247 guests and 239 exhibitors.

County Association Officers

FAIRFIELD COUNTY

President: Nathaniel B. Selleck, 215 Main Street, Danbury.

Vice-President: James D. Corridon, 119 West Avenue, South Norwalk.

Secretary: Michael A. Dean, 881 Lafayette Street, Bridgeport.

Treasurer: Joseph C. Quatrano, 893 Clinton Avenue, Bridgeport.

Councilor: C. Louis Fincke, 21 Broad Street, Stamford.

Alternate Councilor: John P. Gens, 64 Wall Street, Norwalk.

HARTFORD COUNTY

President: Thomas M. Feeney, 701 Asylum Avenue, Hartford.

Vice-President: Harold M. Clarke, 99 West Main Street, New Britain.

Secretary-Treasurer: Philip M. Cornwell, 85 Jefferson Street, Hartford.

Councilor: John N. Gallivan, 400 Main Street, East Hartford.

Alternate Councilor: Harold M. Clarke, 99 West Main Street, New Britain.

LITCHFIELD COUNTY

President: Richard I. Barstow, Village Green, Norfolk.

Vice-President: John F. Kilgus, West Road, Litchfield.

Secretary-Treasurer: Isadore S. Goldberg, 24 Church Street, Torrington.

Councilor: Frank D. Ursone, Greenwoods Road, Norfolk.

Alternate Councilor: Royal A. Meyers, 162 Main Street, Watertown.

MIDDLESEX COUNTY

President: Willard E. Buckley, 28 Crescent Street, Middletown.

Vice-President: Joseph Magnano, 100 Broad Street, Middletown.

Secretary-Treasurer: Vincent J. Vinci, 70 Crescent Street, Middletown.

Councilor: F. Erwin Tracy, 164 Court Street, Middletown.

Alternate Councilor: Willard E. Buckley, 28 Crescent Street, Middletown.

NEW HAVEN COUNTY

President: Michael J. Conroy, 64½ East Main Street, Meriden.

Vice-President: Jacques H. Green, 171 North Main Street, Waterbury.

Secretary-Treasurer: Cole B. Gibson, 362 Whitney Avenue, New Haven.

Councilor: Walter I. Russell, 139 Alston Avenue, New Haven.

Alternate Councilor: Christopher E. Dwyer, 18 Pine Street, Waterbury.

NEW LONDON COUNTY

President: Eric H. Blank, 326 State Street, New London.

Vice-President: Lewis Sears, 257 Main Street, Norwich.

Secretary-Treasurer: William J. Muray, Jr., 437 Montauk Avenue, New London.

Councilor: Henry A. Archambault, 2 North Second Avenue, Taftville.

Alternate Councilor: Richard M. Starr, 228 William Street, New London.

TOLLAND COUNTY

President: William Schneider, 72 Orchard Street, Rockville.

Vice-President: Oliver J. Purnell, 147 Union Street, Rockville.

Secretary-Treasurer: R. Bruce Thayer, Jr., Main Street, Hazardville.

Councilor: John E. Flaherty, 42 Elm Street, Rockville.

WINDHAM COUNTY

President: Robert Dinolt, Bradley Theatre Bldg., Putnam.

Vice-President: Olga A. Little, 715 Main Street, Willimantic.

Secretary-Treasurer: Frederick A. Beardsley, 59 Church Street, Willimantic.

Councilor: Edward J. Ottenheimer, Windham Community Hospital, Willimantic.

Alternate Councilor: Ralph L. Gilman, Storrs.

Meetings Held in May

May 12—Council

Committee on Public Health

AMEF Committee

Sub-Committee on School Health

May 13—Committee on Postgraduate Education

May 16—Conference on State Hospitalization

Cancer Coordinating Committee

May 23—Connecticut Health League.

May 25—Committee on Industrial Health

New Members

LITCHFIELD COUNTY

Max Bernanke, Brookfield

MIDDLESEX COUNTY

James R. Glessner, Jr., Middletown

Kenneth F. Greene, Middletown

Recommendations and Resolutions Adopted by House of Delegates, April 26, 1955

MEDICAL SCHOOL SCHOLARSHIPS

The Council recommends to the House of Delegates that the sum of \$2,500 be allotted from the surplus funds of the Society to provide five scholarships of \$500 each for the academic year 1955-1956. These scholarships are to be awarded to young men

or women whose homes are in Connecticut and who are enrolled in the fourth or final year in an approved medical school in the United States or Canada.

For the purpose of selecting the recipients of these scholarships, the President shall designate three members of the Society to serve as a confidential Committee on Scholarship Awards. The identity of the members of this Committee shall be known only to the President, President-Elect, the three members of the Committee and the Executive Secretary who shall serve as correspondent for the Committee.

RETIREMENT PLAN FOR EMPLOYEES

The Council recommends to the House of Delegates that the Society adopt a retirement plan for its employees (exclusive of the present executive secretary). The plan to be of the pension trust type, written by the Connecticut General Life Insurance Co. and paid for by contributions from the Society and employees covered. An appropriation of approximately thirty-five hundred dollars is hereby authorized to place the plan in operation retroactive to January 1, 1955. Commencing with 1956, a sum sufficient to finance the Society's payments under the plan shall be included in the annual budget. The Council is directed to take all steps necessary to implement the proposals in this resolution.

A RESOLUTION CONCERNING TREATY POWER INTRODUCED BY THE COMMITTEE ON PUBLIC RELATIONS

WHEREAS: Article VI of the Constitution provides that: "This Constitution, and the Laws of the United States which shall be made in pursuance thereof; and all Treaties made, or which shall be made under the Authority of the United States, shall be the supreme law of the land; and the Judges in every State shall be bound thereby, anything in the Constitution or Laws of any State to the contrary notwithstanding," and,

WHEREAS: The Constitution thus makes laws of Congress the supreme law of the land only when made in pursuance of the Constitution, while treaties are the supreme law of the land when made under authority of the United States, but without requirement that they be pursuant to the Constitution, and,

WHEREAS: The history of the drafting of the Constitution indicates that its framers never contemplated, when they wrote the "treaty supremacy" clause, that treaties would seek to regulate our freedoms, our behavior, our daily lives, our economic system and even our form of government, and,

WHEREAS: "Executive agreements" have been generally used to conclude international agreements that were more temporary in character or of relatively minor importance as compared to treaties, and,

WHEREAS: "Executive agreements," "treaties" of the United Nations and "conventions" of the International Labor Organization now are accepted on the same basis as treaties as mentioned in the Constitution, therefore

BE IT RESOLVED: That the Committee on Public Relations of the Connecticut State Medical Society go on record favoring the passage of Senate Joint Resolution I, to wit:

Article

"Section 1. A provision of a treaty or other international agreement which conflicts with this Constitution, or which is not made in pursuance thereof, shall not be the supreme law of the land nor be of any force or effect.

"Section 2. A treaty or other international agreement shall become effective as internal law in the United States only through legislation valid in the absence of international agreement.

"Section 3. On the question of advising and consenting to the ratification of a treaty, the vote shall be determined by yeas and nays, and the names of the persons voting for and against shall be entered on the Journal of the Senate.

"Section 4. This article shall be inoperative unless it shall have been ratified as an amendment to the Constitution by the legislatures of three-fourths of the several States within seven years from the date of its submission."

Resolutions Defeated

RESOLUTIONS FROM THE COMMITTEE TO STUDY
MATERNAL MORTALITY AND MORBIDITY

WHEREAS: The Report of the Committee on Study of the Organization and Objectives of the Connecticut State Medical Society in 1949 recommended that members of the Council not be nominated as chairmen of committees and this report was approved by the House of Delegates and

WHEREAS: A kind of a regulation has been adopted by the Nominating Committee that members of the Council shall not be nominated as chairmen or members of the Society's committees, and

WHEREAS: It is the unanimous opinion of the Committee to Study Maternal Mortality and Morbidity that this regulation imposes an unnecessary restriction on the nomination and appointment of members of the Council to committees when often they would be valuable and interested members,

The Committee to Study Maternal Mortality and Morbidity unanimously recommends to the House of Delegates that all restrictions on the nomination or appointment of members of the Council to the Society's committees be removed.

THE HISTORIAN'S NOTE BOOK

The letter which is being reproduced below was shown to me by Mr. Merrill K. Lindsay, son of a former professor of orthopedic surgery at the Yale University School of Medicine. Mr. Lindsay found it, among others, in a house which he bought in North Branford in 1948.

The house was built by the Chidsey family in about 1810-1820 and remained in their possession until bought by Mr. Lindsay after the death of Miss Mary Chidsey at the age of 100.

Other letters in the collection would indicate that this letter had been in the possession of the Bronson family of Waterbury, one of whom visited in North Branford. The Bronson family was represented in the medical profession of early Waterbury and also of New Haven.

No trace of the volume referred to in the letter has been found, either in the Yale Medical Library or in the office of the New Haven County Medical Association.

It is hoped that this letter will stimulate a search for the missing volume.

Sincerely,
Dana L. Blanchard, M.D.

Gentlemen

Philadelphia Oct. 6. 1789

I beg you will be pleased to communicate to our Indecor of Society at New Haven my sincere and hearty thanks for your present of Copies and Manuscripts; I present not only valuable in itself, but rendered doubly so to me, by the polite Letter which accompanied it. I am deeply that my Endeavour to diffuse & stir up others to diffuse the Light of useful knowledge through this, yet, new world, this rising Country, has met with your kind Approbation.

I should not have so long delayed to express my grateful Acknowledgment for your politeness; but neither the book, nor the Letter reached my hand, till after my Return from Carolina, a few Months ago, when I went upon a Visit for my Health; & when I expect shortly to return for the benefit of a milder Winter, & under which I know of no safe conveyance, till that which now offers

Cn

Doct^r John Morgan
Letter Oct 6 1789

Of the Committee of the
Medical Society of
New Haven County
in Connecticut
of Dissection &c

In return for your friendly communications, the Society will soon design to accept the Volume I now send you herewith, containing *Theses, Lectures, Dissertations and Addresses to the public on the subjects of Learning, and the Advancement of useful Science, especially Medical, in North America.*

I add thereto, in two loose Papers, an Oration delivered by me, a few months ago, before a Society of Literati at New Britain. If you condescend to review these in good part, as small tokens of my esteem, I give them a place in their Collection of Books and Papers, I shall esteem it an additional favour to the one they have already conferred upon me.

Please to present the Society with my sheets, and my earnest desire that it may flourish, & produce an abundant good fruit. If their Labour & Groove a *Source of Advantage* and an honour to their Country, it is useful as well as highly ornamental to these Members.

To you in particular, my thanks are due for your care of the present to me.

I remain, very respectfully.

Gentlemen

Your much obliged

most obedient &

very humble servant

John Morgan

[Signature]

To Messrs. Leverett Hubbard, Committee
of Congress, of
Messrs. Beardsley,
Sargent, Porter,
Sam. & Vassett
of the Medical
Society of New
Haven, formerly
in
Connecticut

[Initials]

Special Article

FEDERAL REINSURANCE

C. MANTON EDDY, *Hartford*

PROPOSAL BEFORE 1954 CONGRESS

The reinsurance proposal of the Administration was first disclosed by President Eisenhower in his State of the Union message on January 7, 1954. In that message the President repeated his fundamental opposition to the socialization of medicine. He stated that medical costs were rising and frequently imposed severe hardships on many families. He added that hospital and medical insurance plans were already in the field and he submitted that a limited government reinsurance service would permit health insurance organizations to offer broader protection to more of the many families which want and should have it.

Subsequently, in the Health message and in the Budget message the program was referred to but still only in very broad outline. The public reaction, however, was extremely favorable and the press reports complimentary. Because of the immediate lack of detail there were many who assumed that the reinsurance program would reach into areas of the health problem which it was never intended to reach. By the time the bills were actually presented in Congress in March, expectations had been built to the point that the modest and sound program as presented in detail was disappointing to many. In the end, in midsummer the bill was defeated by a surprising coalition of those who said the bill went too far and those others who said it was entirely inadequate. The paradox that extremists found objection through opposite viewpoints perhaps bears witness that the program applies a middle-of-the-road philosophy to a complex and difficult problem.

In February of this year a revised reinsurance bill was introduced in the Congress. The revisions were intended to meet objective criticism which had been levied the year before. In the discussions of the program both this year and last year there has been

The Author. *Vice-President and Secretary, Connecticut General Life Insurance Company*

SUMMARY

The federal reinsurance bill was defeated, paradoxically, by a coalition of those who thought the bill went too far and those who thought the bill inadequate.

Insurance should protect against unforeseen financial drain, not pay for routine medical bills. Reinsurance is a way of sharing the risk among several insurers. The federal bill was designed to reinsure on an excess loss basis, a form of reinsurance which covers losses when they exceed a stipulated amount for a single catastrophe.

The bill said in effect we want private carriers to undertake greater risks and give broader benefits. Medical progress has been so great that the numbers of the chronically ill and aged have increased, thus adding to the nation's total health problem. The bill was not designed to solve the problem of the indigent, however, but the problem of financial drain that makes a normally self-sufficient family nonsupporting.

If voluntary insurance can be extended to more of these people and benefits can be increased to cover times of abnormal expense, the national health problem can be greatly reduced.

Insurance carriers, however, have been cautious in developing such coverage. Some companies have developed major medical or catastrophe plans but more plans are needed. It is to this problem that the federal bill applies. Under it the federal government would cover losses beyond a stated limit, thus encouraging extended coverages and expanding benefits.

The bill does not carry the threat of socialization since it would be voluntary, supervised by States rather than federal government, and would provide only coverage of a portion of abnormal losses.

Presented before the Hartford County Medical Association at Hartford, Connecticut, on April 5, 1955

evidence of some misconception and misunderstanding and at times of an emotional rather than an objective approach. In order to form objective judgments it is necessary to look at the bill carefully against the background of the health problems of the nation, to see what it is and what it proposes to do.

WHAT INSURANCE REALLY IS

As all of us know, insurance is simply a sharing of risk by a large number of individuals. The financial burden of misfortune which comes to a few is made bearable by having it shared by the contributions of the many. Insurance is at its best when it protects against events that are unlikely but which carry with them financial catastrophe when they occur. Insurance is at its worst when it protects against events which are frequent and in which the financial impact is minor. To use simple illustrations, insurance is most valuable when it is like the fire insurance which protects the home owner against the financial loss that would follow destruction by fire. Insurance is quite unimportant when it protects against the cost of replacing a few shattered windowpanes in the home. Insurance that reimburses for the cost of repairing broken bodies resulting from a serious automobile accident is most important. Insurance that attempts to reimburse for the cost of annual medical examinations is hardly wise. The event is certain, the costs are reasonably known in advance. There is no real sharing of risk, there is merely the adding of insurance overhead to the program which could be best handled by individual budgeting.

Reinsurance in turn is a well known device of sharing risk among insurers rather than among individuals. In itself it is almost as old as insurance. It exists in all fields of insurance: fire, casualty, life, health, and so on. It is a means by which an insurer can equalize his risks with the help of other insurers. The availability of reinsurance enables the small company to undertake large risks as does the big company. It enables the conservative company to undertake broad risks as does the bolder company. By passing on a portion of the risk to other insurers the original underwriter can make certain that the risk he holds is not excessive as to his ability to pay or as to his surplus funds in the event that misfortune or epidemic strikes.

Reinsurance generally takes the form of one of two types. The first is reinsurance on a share basis, the second is reinsurance on an excess loss basis.

REINSURANCE ON SHARE BASIS

Reinsurance on a share basis is most frequently used in this country and particularly so in the life insurance business. For example, the large life insurance companies are willing to underwrite, let us say, a limit of \$200,000 on an individual risk and are willing to undertake it without assistance from anyone. Smaller companies may wish competitively to undertake equal amounts of risk but because of size find it advisable to avoid any excessive hazard by limiting loss in one individual case to a smaller figure. Therefore, while such a company may underwrite \$200,000 of insurance on a given life, it may in turn reinsure \$150,000 of that with one or more other insurance companies. In this way the impact of possible loss through one occurrence is reduced.

REINSURANCE ON EXCESS LOSS BASIS

Reinsurance of the excess loss type is less well known in this country but it is found at times in the casualty field. Protection may be sought against the possibility that total liability arising out of one occurrence or misfortune will exceed a given limit. An explosion in an industrial plant could destroy many lives and leave many crippled bodies. The losses might run into the millions. The underwriter may wish to protect itself by securing reinsurance which covers losses in whole or in part as they exceed that first million dollars.

All reinsurance is based on the sound principle of not having too many eggs in one basket. If an insurance company will only give the law of averages a chance to operate it will be sound. If it has unbalanced underwriting risks, it is speculating and that is not the function of an insurance company.

The reinsurance proposal of the Administration followed the principles of the excess loss type of reinsurance. It said in essence we want you underwriters of health insurance to undertake new risks and to undertake broader and broader benefits. We know that it is possible that in experimenting in new fields, particularly with larger potential limits of loss, your calculations may prove wrong or may temporarily work out badly before the law of averages has an opportunity to operate. Through reinsurance we can minimize the danger that miscalculation or temporary fluctuations in losses can upset your financial position.

Before speaking specifically of the proposed reinsurance operation I would like to touch briefly on

some of the problems that have developed in financing the cost of care and on the development of voluntary health insurance.

ADVANCE IN MEDICAL SCIENCE

The great strides made in medical science and medical care within the last few decades are almost unbelievable. The physician today has within his resources powerful tools for diagnosis and for treatment. These do not, of course, and never will replace the understanding and the judgment that the physician brings to the treatment of each patient because medicine itself, you all will agree, is not and can never be a mechanistic science. These new weapons against illness and disease are sometimes quite expensive and have added to the costs of treatment. Also the saving of many lives today, lives which in a previous generation would have been lost, has brought about survival for many more to take their place in the ranks of the chronically ill and of the aged. This has resulted in an increase in the total bill for health care for the nation.

It is conceded that there are serious problems affecting the health needs of the nation. There is on one hand the problem of making available adequate medical care for all who need it. There are sections of the country where it is clear that medical facilities and competent personnel are not sufficiently available.

The second part of the problem is finding the means of financing properly the cost of the medical and hospital care that is provided.

REINSURANCE NOT FOR INDIGENT

We know that there are in our society those unfortunates who cannot pay any part of the cost of care, whether it is at the time of illness or in advance by budgeting through the payment of insurance premiums. These are people without income, on relief, wards of government. They are the indigent and their care must be at the expense of someone else. It may be the doctor who gives his time freely, it may be through private charity, or it may be by means of public relief at some level of government. The problems of such a group cannot be ignored. But these problems were never intended to be reached by the Administration's reinsurance bill and I emphasize this because there has been some misconception on this point. The reinsurance bill was never intended to be a solution to the problem of the indigent.

There are many people in our society with modest incomes and limited resources who presumably can find the means within their budgets of paying regular premiums toward insurance protection. But they are people whose slender resources can hardly stand the impact of sizeable medical and hospital bills. For want of a better definition such individuals have been termed medically indigent, people who are normally self supporting but become nonsupporting in the face of heavy expenses of illness.

VOLUNTARY MEDICAL INSURANCE

If voluntary insurance can be extended to reach more and more people in this class and if the benefits of voluntary insurance can be expanded to cover the impact of the extended and expensive illnesses as well as those of shorter duration and more limited cost, the problem areas in the health field in this country will have been substantially reduced. The basic object of the reinsurance bill was to encourage such expansion of voluntary insurance.

The field of voluntary health insurance is relatively a new one. It developed first through hospital expense insurance which started by and large in the middle 1930's and by 1939 had been obtained by only six million Americans. Today it is estimated that over 103 million people have the benefits of such protection. The increase in numbers is truly dramatic and in part bears on the deep interest of the American people in having sound protection.

The protection, however, is developed on the basis largely of paying costs from the outset for a limited period. Originally protection extended to only 21 days of hospital care. Many programs today are still limited to that period of time. The most usual benefits cover 30 or 31 days of hospital stay. Occasionally benefits run to 70 days and under certain conditions even longer. It is true that as far as the acute general hospitals are concerned over 90 per cent of the costs of hospital care are covered by 30 day protection. But I think it is cold comfort to one who has the misfortune to be involved in long-term and expensive illness to be told that his case is one that was statistically unlikely. It has happened to him and the bills are burdensome, perhaps beyond his ability to pay.

Insurance for surgical benefits developed shortly after hospital insurance and today some 88 million people have protection. Insurance against the cost of medical care other than surgery is held by some 47 million Americans. Here too the customary

benefits are available only with limits on total dollar expenditure, so that average and usual costs are cared for, yet the less likely but more expensive bills still fall back on the individual.

CATASTROPHE INSURANCE

Because there is an obvious need for protection where insurance does the most good—namely, the infrequent occurrences of great financial impact—the insurance business has attempted to solve the problem through plans that have been variously called major medical or catastrophe coverage. Such coverages use the principles of deductibles and co-insurance. The deductible provision means that the first dollars of expenses are borne by the individual himself. The co-insurance principle means that as expenses are incurred they are shared between the individual and the insurer, usually in the ratio of 25 or 20 per cent for the individual and 75 or 80 per cent for the insurer. There is usually an outside limit placed on total reimbursement which may be \$5,000 or even \$10,000.

Experiments in this field started some six years ago, but as of today coverage of this sort is possessed by only a million and a half people. Progress in this area has seemed somewhat slow and cautious. Perhaps it is understandably so. But it is to this point that the reinsurance proposal of the Administration addresses itself in the belief that sound reinsurance will encourage experimentation to mitigate the impact of heavy expenses and to alleviate many of the problems.

ADMINISTRATION REINSURANCE PROGRAM

Now as to the reinsurance operation as proposed by the Administration. I will try to describe it, not in detail, as I am sure you are not interested in that, but in the simplest terms that I can. An insurance company might wish to enter the major medical field for the first time. One already in it with a co-insurance factor returning 75 per cent of costs might wish to experiment with more liberal policies that returned 90 per cent of costs. A Blue Cross plan which had previously limited its benefits to 30 days might wish to experiment in the prolonged illness field for a period of 730 days. Actuaries and underwriters, of course, would spend a great deal of time in analyzing available statistics, in making calculations, and in arriving at what was felt to be an adequate rate. The rate would be sufficient to cover expected claims, to cover necessary expenses, and to provide a small margin for contingencies.

Let us say, for the sake of illustration, that the plan was geared to an expected loss rate of 80 per cent, that expenses were expected to be 16 per cent and the margin of contingencies, 4 per cent. Such a plan would be eligible for the government reinsurance at an appropriate premium calculated to be self supporting. The reinsurance rate would be quite small because the calculations of the underwriter had been made conservatively by all available information. The underwriter was seeking the protection of reinsurance because in an experimental field he did not wish to undertake the possibility, however remote, of having a substantial loss in the event of unforeseen or unknown circumstances. So in the case at issue we have a contemplated 80 per cent loss rate, 4 per cent for contingencies, and 16 per cent for expenses. The reinsurance formula in the bill sets out that the government's liability as reinsurer does not come into being until the actual loss rate exceeds not only the 80 per cent contemplated, but also the 4 per cent for contingencies and also $\frac{1}{8}$ of the expenses; that is, 80 plus 4 plus 2, or 86 per cent. With a loss rate in excess of 86 per cent the government would share the excess with the original underwriter, 75 per cent assumed by the government, 25 per cent by the original underwriter. I have used a specific case for an illustration. According to the general formula, before the government would share in excess losses, losses would have to exceed both the allowance for normal losses and the allowance for contingencies, and use up $\frac{1}{8}$ of the company's allowance for expense. It is a very conservative formula which provides no opportunity for profit to the original underwriter. The value is that it enables an underwriter to back his own judgment in a new and experimental field, to undertake larger risks than he had done before, and for a small reinsurance premium to have protection against the remote possibility of totally unexpected results. Obviously no underwriter is going to plan intentionally to conduct experiments that will cost money even though the government may be paying three times as much of the loss as does the underwriter. You may ask, then, if the underwriter does not intend to lose, why should he reinsure? And the answer is found in the whole philosophy of reinsurance wherein the original underwriter in normal business practice equalizes extremes of exposure and liability that he undertakes.

In reaching an objective judgment on the reinsurance proposal, I think it is worthwhile for us to

take a quick look at the backdrop of the political and social scene against which this proposal has been made.

Well over a decade ago there were strong and vocal proponents of compulsory health insurance for the nation. Statistics of draft rejections for physical reasons were seized upon and misapplied as evidence that the national health was suffering. Experiments in other countries were pointed to as evidence of social progress there and of a backward spirit here. The Murray-Wagner-Dingell type of bill perhaps epitomized the political controversy that raged around the issue of compulsory health insurance.

You gentlemen and your colleagues individually and through your societies and associations did the country valuable service in alerting it to the inherent dangers of socialized medicine that goes hand in hand with any compulsory national health program.

The attitude of the public has definitely changed, if we can accept the surveys of the National Opinion Research Corporation. Surveys in 1940 indicated 60 per cent of the population were favorable to compulsory health insurance, whereas recently their surveys show the figure has dropped below 20 per cent.

But while the danger of a compulsory program may now be remote, there has been much legislation before Congress in which I think there is real cause for alarm. Conservative Republicans have sponsored bills creating subsidies for prepayment plans designed to aid the medically indigent. It is assumed that those in low income or moderate income groups are able to pay part of the premiums for the cost of hospital and medical care but not all. Therefore, by arranging a plan with premiums geared to income—the lower the income, the less the premium—proper protection can be made available with the federal government making up the deficit between what is paid and what is the proper cost.

COMPULSORY INSURANCE FEARED

Gentlemen, it seems to me that a voluntary plan of prepayment insurance, subsidized in good part by government funds, with the premium as respects the individual a percentage of his income up to some ceiling limit, would be but one step removed from translation into a compulsory scheme of prepayment insurance with the tax to the individual levied as a percentage of income, the balance of the cost being subsidized by general revenue of the govern-

ment. Such legislation in particular would bring great dangers.

There has continued to be political pressure for legislation respecting matters of health. However, conservatives and middle-of-the-roaders have real cause for concern when they review critically practically all of the legislation that has been proposed in recent years. Much of it seems to lead to socialization of medicine. Most of it seems to involve subsidy by federal funds and much of it involves Administration at the federal level.

PRINCIPLES OF REINSURANCE BILL

On the other hand the proposed reinsurance bill has been shaped according to principles which, I believe, are exceedingly important and sound. These are the fundamentals:

1. Participation by a carrier is entirely voluntary.
2. Participation is open both to insurance and service type organizations.
3. Supervision of carriers remains with the States.
4. Federal reinsurance would operate only where comparable reinsurance is not available from private sources.
5. Reinsurance payments are made only for abnormal losses, where such losses have exceeded normal anticipated losses plus all margins for contingencies plus one-eighth of the expense margins.
6. Through co-insurance the carrier shares 25 per cent of its abnormal losses.
7. The system is without subsidy; reinsurance premiums are to be fixed with a view toward keeping the system self supporting.

Criticism levied at the bill last year was at times emotional and at times objective.

It has been said that the program would not be useful, that it would, in fact, be inadequate and its deficiencies would stimulate a turning toward national health insurance. Objectively it would seem to me that it is impossible to be sure that a program would not be used without trying it. And I think that there is evidence that there are those who would use the program. In any event, if it proved on trial to be of little use, it would seem to be far removed from any path toward national health insurance. This country will embrace compulsory health insurance only when its citizens wish to do so. If that is the case, and I certainly hope it will never be, new specific legislation is the direct route.

It has been argued that the program would compete with the private insurance business and that

this was contrary to the avowed purpose of the Eisenhower Administration to remove government from business as far as possible.

In point of fact there appears to be no source in this country of excess loss reinsurance of the type proposed. But I would call to your attention also that the bill has spelled out that the Secretary would offer reinsurance to a plan only if comparable reinsurance is not available from private sources.

It has been held that the bill would create federal regulation of insurance which would supplant State supervision of insurance.

During the past year the Administration has consulted with representative insurance commissioners and I understand has adopted their suggestions relative to strengthening the bill to make clear that the Administration's purpose is not to supplant State supervision. Among other things it is provided that two members of the advisory council, which is created by the bill to advise with the Secretary, shall be state insurance commissioners.

It was said last year that the bill was too general and gave the Secretary too broad authority.

IMPROVEMENTS OVER FORMER REINSURANCE BILL

The redrafting of the bill has pin pointed more specifically areas in which it is hoped that the bill will be useful and the suggestions of last year's congressional committees as to limitations on powers of the Secretary have been included.

It was said that the bill did not help the indigent.

I have said earlier tonight that the proposal made no attempt to solve the problems of the indigent and of those needing public assistance. These are, of course, very real problems and need other approaches. No attempt last year was made in any legislation to provide federal funds in this area.

This year the redrafted reinsurance bill is a part of an omnibus bill addressing itself to other facets of the health problem. One section provides for mortgage insurance to finance construction of health facilities. Another addresses itself to federal grants in aid for training of practical nurses and for grants in training of professional nurses and of professional public health personnel. Other provisions of the bill relate to grants to the States for public health services and to grants to the States for mental health services. Another Administration bill before Congress proposes specifically certain grants to the States for the medical and hospital care of those who are recipients of public assistance.

BENEFITS FROM REINSURANCE BILL IN CONGRESS

Whether or not the reinsurance bill becomes law I can see definite benefits that have already accrued from it. It has created a great deal of discussion of health problems and it has concentrated attention on the need for more extended insurance benefits. There is far more activity in the insurance field in this respect than before. There is current activity in Blue Cross and Blue Shield circles to make possible protection in the event of prolonged illness. There is activity in the insurance field toward the formation of reinsurance pools to make unnecessary any government reinsurance operation. Perhaps some of this is motivated by the fear of government in business and a desire to keep government out of business. Whatever the motives, it can be said that the activity appears productive of useful and fruitful results.

All of us—doctors, hospitals, insurance men, the public—are interested in the same health goals and I think accomplishments to date will be exceeded by the accomplishments of tomorrow.

EDITOR'S NOTE

The administration's recommendation for the reinsurance of health services prepayment plans is embodied in Title I of HR3458, introduced by Representative Priest of Tennessee. According to the Department of Health, Education, and Welfare, the Reinsurance Fund would not be reinsuring the benefit payments for any particular policy-holder or subscriber, nor would it insure a carrier as such. It would protect a carrier against bad experience in the aggregate under the particular reinsured plan. The only losses by a carrier that would be reinsured would be those that are abnormal and in excess of those anticipated when the plan was approved and sold to subscribers. The carrier would share in paying the abnormal losses. The program would be entirely voluntary on the part of commercial insurance companies and voluntary nonprofit associations.

The Department explained that only prepayment plans engaged in one or more of the following would be eligible for reinsurance:

1. Experimentation in developing coverage to provide average and lower income families with policies giving broader protection against the costs of hospitalization and physicians' services in the hospital, in the doctor's office, and in the patient's home.
2. Developing insurance against exceptionally high costs of serious or prolonged illness.
3. Improving voluntary health insurance coverage for rural families.
4. Enlarging the scope of voluntary health insurance coverage or improving the benefits it provides.

A further condition for granting reinsurance would be specific standards for: (a) minimum benefits; (b) safe-

guards against undue exclusions or limitations; and (c) waiting periods for benefits.

In an article, "Why Federal Health Reinsurance Isn't the Answer," published in the January-February Issue of *American Economic Security*, Edwin J. Faulkner, President, Woodman Accident and Life Company, points out, "Without government subsidy to make insurance available at less than cost, a departure not now contemplated by the plan, federal health reinsurance would contribute nothing to the financing of the health care costs of those not presently eligible for insurance." For example, the indigent and some persons now suffering from impaired health are not presently eligible.

Dr. Braceland Chosen Head of American Psychiatric Association



FRANCIS J. BRACELAND, M.D.

Francis J. Braceland, psychiatrist-in-chief of the Institute of Living, Hartford, was named president-elect of the American Psychiatric Association at the annual meeting of the organization in Atlantic City, May 9-13. Prior to accepting his appointment at the Institute of Living in July, 1951, Dr. Braceland was head of the Section on Psychiatry at the Mayo Clinic. He directed the psychiatry branch of the Navy Bureau of Medicine and Surgery during World War II and was awarded the Legion of Merit.

Before the war Dr. Braceland was dean of the School of Medicine and professor of psychiatry at

Loyola University, Chicago, and prior to that served as assistant professor of psychiatry in the Graduate School of the University of Pennsylvania and associate professor of psychiatry at the Woman's Medical College in Philadelphia.

He received his medical degree at Jefferson Medical College in 1930 and was awarded a Doctor of Science degree at LaSalle College in 1941.

As a member of the Medical Task Force of the Hoover Commission, earlier this spring Dr. Braceland wrote the report on mental hygiene which was presented to Congress. The report called nationwide attention to the problem of mental illness.

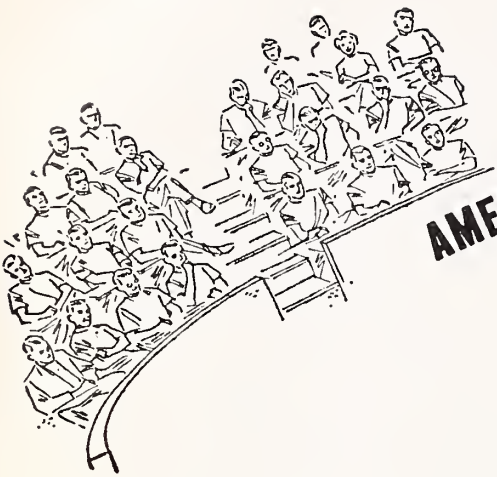
Dr. Braceland is currently on the Health Resources Advisory Committee and the National Advisory Committee to Selective Service. He is consultant to the Surgeons General of the Army and Navy. He has served as chairman of the committee to certify psychiatrists as qualified mental hospital administrators and as secretary-treasurer and then president of the American Board of Psychiatry and Neurology, which is the examining body passing upon the professional qualifications of psychiatrists.

Prior to his selection as president-elect of the Association, Dr. Braceland was coordinator of professional affairs for the association. He is at present a trustee of the Association for Research in Nervous and Mental Diseases and chairman of the Section on Nervous and Mental Diseases of the American Medical Association.

New Pamphlet Lists "Ups" In Medical Education

Record achievements by our nation's medical schools during the past year are emphatically pointed up in an attractive new 12 page pamphlet currently in production by the American Medical Association. The pamphlet entitled, "What's Up With Our Medical Schools?" discusses four main phases of medical education in which the 80 approved medical schools in the country now are surpassing all previous records. These areas are: (1) medical school enrollments; (2) number of medical school graduates; (3) medical school finances, and (4) medical school facilities.

Particularly suitable for distribution in doctors' reception rooms, through schools and at health fairs, quantities of the pamphlet will be available after July 1 from state medical societies or the AMA's Public Relations Department.



AMERICAN MEDICAL



EDUCATION FOUNDATION

Connecticut Committee
160 ST. RONAN STREET
NEW HAVEN 11, CONN.

May 10, 1955

Dear Doctor:

America's 80 medical schools are in the forefront of great progress. They are challenged by the growing demands of modern society at a time of financial stress, when many of them find it difficult to meet current operating costs without help.

In this crisis, the American Medical Education Foundation seeks to implement the obligation of our profession to help medical education.

Won't you help by contributing as generously as you can to the Foundation's 1955 campaign?

Our Connecticut campaign last year brought \$125,000 from 1,407 members of the Society's 3,000 members. It showed that 22,996 physicians contributed.

The AMEF Committee extends sincere appreciation to the hundreds of physicians who have already responded to this appeal, mailed May 10th.

AMERICAN MEDICAL EDUCATION FOUNDATION

Fund-Raising Committee

CONNECTICUT STATE MEDICAL SOCIETY

160 ST. RONAN STREET, NEW HAVEN 11, CONNECTICUT

I wish to contribute the enclosed amount to help our medical schools.

Please earmark my contribution:

1. For AMEF General Fund ☐
2. For _____
(Name of Medical School)



Signed: _____ M.D.

Office Address: _____

Date: _____

CHECK SHOULD BE PAYABLE TO AMERICAN MEDICAL EDUCATION FOUNDATION

Contributions are deductible for income tax purposes

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New Haven Emergency Service Reports Active Year

The Emergency Medical Service of Greater New Haven processed 1,192 calls during 1954, according to the annual report of Samuel Spinner, chairman of the New Haven Medical Association's committee to supervise the service.

Requests for emergency medical aid numbered 864, an average of 72 per month, while 338 calls concerned information about selection of physicians.

During the year, 119 physicians responded to calls through the Emergency Medical Service and an average of three physicians were contacted per call. A number of physicians responded to one call and many to several calls, while one physician answered a record 93 calls for the twelve month period.

The report highly praises members of the voluntary emergency panel for their services to the community.

"The cost of this service," the report concludes, "is borne by our medical association and amounted to about \$600 for the year 1954. It is my feeling that this is a very inexpensive way of not only doing a lot of good for the communities in which we live, but also of maintaining the favorable position which the medical profession holds in the minds of the majority of the public."

Hartford County Medical Association Sponsors Videclinic

"Mind and Medicine," a nationwide closed circuit television report on new developments in the treatment of mental illness, was attended by more than 300 Hartford County physicians the evening of May 9.

The videclinic was presented at the Talcott Junior High School, in Elmwood, under auspices of the Hartford County Medical Association. The program was telecast to physicians in 34 cities as the second in the new series entitled "Medical Journal of the

Air," presented by the American Medical Association and produced by the Smith, Kline and French Laboratories, Philadelphia.

Francis J. Braceland, psychiatrist in chief at the Institute of Living, Hartford, was a principal participant in the telecast, which featured reports by 14 authorities in the field of mental health.

Thomas M. Feeney, president of the Hartford County Medical Association, welcomed physicians to the telecast, which was produced in cooperation with the American Psychiatric Association. It was viewed by more than 25,000 physicians on six-foot motion picture screens placed in hotel and school auditoriums in major cities.

Naugatuck and Mystic Areas Study Emergency Plans

Preliminary plans have been made by the Lower Naugatuck Valley Medical Association to expand membership on the physicians' panel for operation of emergency medical services.

The action was taken at a recent meeting of the Association. It provides for extending the services to surrounding communities.

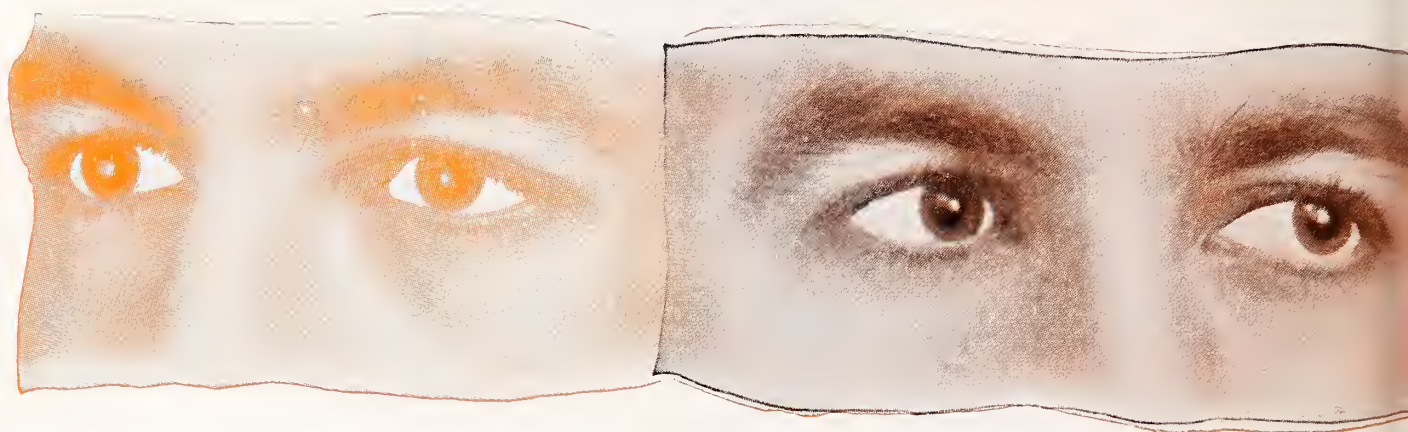
In Mystic, local physicians are studying plans to provide weekend emergency services through an assignment system. It would comprise the publication of the name of the physician on emergency call in each Friday issue of the *New London Day*.

New Radio Series in Stamford

Radio Station WSTC, Stamford, in cooperation with the Fairfield County Medical Association and the Woman's Auxiliary, recently inaugurated a new series of health education programs.

Titled "Sixteen—and Growing Up," the series comprises 13 weekly transcriptions and is heard at 7:30 P. M. each Monday. The transcriptions are furnished by the American Medical Association through the offices of the State Medical Society. They are available to local medical societies without charge.

MORE AND MORE PHYSICIANS ARE TURNING TO



ACHRO

WHEN A BROAD-SPECTRUM ANTIBIOTIC IS INDICATED





MYCIN*

HYDROCHLORIDE
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Within the first few months of its introduction, ACHROMYCIN was being widely prescribed. Each succeeding month has seen its usage increase as more physicians have come to know and value ACHROMYCIN in its many dosage forms.

More than a year of widespread use has established ACHROMYCIN as a true broad-spectrum antibiotic, well tolerated by both young and old. It has proved effective against a wide variety of infections caused by Gram-positive and Gram-negative bacteria, rickettsia, and certain viruses and protozoa. Compared to certain other antibiotics, ACHROMYCIN provides more rapid diffusion; it is also more soluble, and, once in solution, more stable.

Truly, ACHROMYCIN has become a major weapon in the fight against disease.

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, New York

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OUR MEDICAL WORLD

Denmark and Sweden

Some food for thought for those who advocate the recognition and legalization of euthanasia may be had by pondering the experience of Sweden and Denmark with regard to the legal induction of abortion. Legislation to permit this practice was passed in Sweden in 1938 and amplified in 1946. In 1938 the number of legal abortions undertaken was about 500. Between 1943 and 1951, this number was increased by about 1,000 every year, and in 1951 more than 6,000 legal abortions were induced. The total of such abortions from 1939 to the present probably exceeds 45,000, this for a population of only seven million people. Seventy per cent of these abortions were among married women, and the same percentage was performed on psychic or physical health indications. Apparently only about 10 per cent are now performed on strictly medical humanitarian or eugenic indications, the rest reflecting social conditions supposed to reduce the vitality of the expectant mother.

The experience in Denmark, whose law was passed in 1939, has been similar. In 1940, 522 legal abortions were performed, and a total of 4,945 cases of abortions treated in the hospitals. In 1952, there were 4,981 legal abortions, and 12,339 cases of abortion treated in hospitals. It is estimated that only 40 per cent of the abortions not induced legally were spontaneous. Seventy-five per cent of the legally induced abortions were in married women. Only about 5 per cent of the 20,000 unmarried women, who become pregnant every year, have a legal abortion, however. In 1940 only 29 per cent of such abortions were induced on psychiatric indications, whereas in 1951, 77 per cent were for these reasons. The birth rate in Denmark has been dropping steadily since 1946.

There are still apparently grave dangers in trying to solve social problems by medical means.

China

Modern, western style medicine has always been available in China only to a relatively few. The wealthy in the cities paid well to secure it, and some

of the poor in the interior received it free from the medical missionaries. The missions have now been virtually eliminated and their facilities destroyed or taken over by Red trained doctors. The majority of western trained city physicians, who still survive, must practice surreptitiously, since their clientele has been largely dispersed or liquidated.

When the Reds took over they set up health centers and roving medical teams to combat epidemics and contagious diseases. They report that cholera has been wiped out, plague reduced by 90 per cent. and smallpox by 95 per cent. Actually the general level of medical care has fallen steadily because of the shortage of trained doctors and the inefficient manufacture of modern drugs in China.

The result has been that the Red Health Minister, Li Teh-chuan, has fallen back on praising the efficacy of herb medicines "proved by several thousand years of clinical experience." Peasants are being ordered to plant more medicinal herbs, government chemists are trying to form pills and concentrates from them by extraction, and government agencies are buying up the supplies to hold prices down.

Clinics for the ancient practices of cautery (searing the skin with burning wormwood leaves), and acupuncture (which involves the cure of disease by thrusting gold or silver needles into the body at a specified angle and to a certain depth) are flourishing. These treatments are being described by Red propagandists as being "90 per cent effective."

India

A primitive system of medicine is still the chief reliance of the 360,000,000 population of the vast subcontinent of India. There are only 60,000 regular physicians to serve this huge mass of people, but over 300,000 homeopathic quacks. Except in two states, there are no restrictions as to who may practice medicine. The ratio of physicians to patients in the cities is 1 to 1,360, and in rural areas, 1 to 20,000. In order to encourage more physicians to take up service in rural areas, the government of Bengal is giving a monthly allowance of 100 rupees (\$21) in addition to a fixed salary. The 35 medical colleges

now produce between 1,700 and 2,000 physicians a year.

The Indian government has, however, taken some important steps in the field of public health. Since the opening of the BCG campaign in 1948, 81½ million persons have been vaccinated and 26 million have been tuberculin tested. The National Malaria Control Scheme has 125 field units operating in highly malarious regions, and in a period of three years hopes to protect from malaria nearly 150 million persons. A Cancer Institute has been set up in Bombay, a Central Leprosy Training and Research Institute in Madras State, and a Maternal and Child Health Center at the All-India Institute of Hygiene in Calcutta. An All-India Mental Health Institute is planned for Bangalore, and the Nutrition Research Laboratory will be moved to Hyderabad.

The ancient "science of life" of India is called Ayur-Veda. It dates back for several thousand years. The older literature refers to the learning of anatomy from the cadaver, the development of over one hundred surgical instruments, and the performance of surgery long before the Christian era. Psychosomatic medicine may be said to have been anticipated by the "Vaidya" or "Vaid," as the Ayur-Veda practitioner is called. They refer to mental counterparts of physical disease, and physical counterparts of mental disease, and believe in treating the patient with emphasis on his emotional, temperamental and spiritual aspects. Due partly to the effect of the invasion of Arabic medicine or Unani, whose practitioners are known as Hakims, the old style practice now consists chiefly in the dispensing of a tremendous variety of drugs derived by simple methods from natural herbs. Rauwolfia serpentina is one example of one of their drugs, which has been adapted to modern, scientific usage. Three institutes have been opened in the last two years to study further the effects of the ancient remedies in scientific fashion. Two of the old schools of medicine are still functioning and Vaidas and Hakims are now starting their own colleges, which will also teach modern medicine.

A-Bomb Radiation Effects on Drugs

Two years ago in Nevada, 42 commonly prescribed drugs and antibiotics were exposed to various levels of neutron and gamma radiation from explosion. Only two of them—insulin and vitamin B-12—

showed any loss of potency attributable to blast radiation according to an Atomic Energy Commission report recently reclassified from confidential. Little or no radiological health hazard would be involved in the normal use of the exposed drugs although those with a high sodium content should be allowed to "cool" for several days before use. Drugs in containers remaining physically unchanged at a distance of 1,000 yards from the explosion of a nominal atomic bomb are considered entirely safe for immediate use.

Lung Cancer Project

At the March meeting of the Executive Committee of the American Cancer Society, Connecticut Branch, Dr. Ottenheimer reported that the Medical Advisory Committee, at its meeting on February 10, had approved grants for two pilot projects, the sums for which had already been earmarked by the Executive Committee. In confirmation, it was

Voted: To approve a grant of \$5,000, previously earmarked, to the New Haven Branch for the development of a lung cancer program as a pilot project, in association with the New Haven Health Department.

Voted: To approve a grant of \$5,000, previously earmarked, to the Connecticut State Department of Health for the development of a lung cancer program in association with the Connecticut Tuberculosis Commission.

Medical Meetings in Washington, D. C. October and November, 1955

Mental Hospital Services Association, October 3-6.

Medical Society Scientific Assembly, October 9-12.

Physicians and Surgeons of Pennsylvania R. R., October 14-15.

American Hospital Association (safety institute), October 17-22.

American Association of Orthodontists (regional), October 23-25.

American College of Osteopathic Surgeons, October 29 - November 3.

Association of Military Surgeons, November 7-9.

Maryland-D. C.-Delaware Hospital Association, November 7-9.

NEWS FROM WASHINGTON

The Bricker Amendment

Again the Bricker resolution is up for official action in Congress. If both houses by two-thirds vote approve the constitutional amendment, designed to restrict treaties to their proper role, the proposal will go to the State legislatures. If three-fourths of them approve it within seven years, the Constitution will be amended. Last year the proposal lost out in the Senate by the narrowest of margins—a shift of one vote would have produced the two-thirds majority. This special report reviews the issue as it pertains to the medical profession, and specifically answers the question: Why do the doctors want the Bricker amendment? The Bricker amendment now is the subject of hearings before Senator Kefauver's subcommittee. Despite Senator Kefauver's opposition, we can expect that the resolution will be reported out of the subcommittee. Approval by the full committee also is likely. We are pointing our efforts, therefore, to a decision on the floor of the Senate.

F. E. Wilson, M.D.,
Director AMA Washington Office

WHY DO THE DOCTORS WANT THE BRICKER AMENDMENT?

The American Medical Association indorses the principle of the Bricker amendment because under twentieth century conditions treaties and executive agreements can and do reach down to affect the general public—and the doctor of medicine. When the Constitution was written, treaties were mainly concerned with tariffs and customs, military affairs and shipping—they had little direct influence on the average individual. Today nations are becoming more and more involved with each other; treaties and agreements touch on everything from a military alliance to professional licensure. The framers of the Constitution could not have anticipated the extent to which treaties would come to affect the domestic life of the country. In 1801, only fifteen years after the Constitution was adopted, Thomas Jefferson considered this same issue and declared: “. . . the Constitution must have . . . meant to except out all those rights reserved to the States; for surely the President and the Senate cannot do by treaty what the whole government is interdicted from

doing in any way.” Safeguards were written into the Constitution to protect the people against abuses from the old-fashioned treaties. The search now is for a safeguard against the modern form of treaty and agreement which concerns itself with broader domestic conditions and relationships.

THE SITUATION AS IT IS TODAY

Under present law a treaty becomes effective after approval by two-thirds of those senators present at the time of the vote. The House of Representatives does not vote on a treaty. The Executive Department regards an executive agreement as effective when it is signed—it need not even be submitted to the Senate for approval. In general, treaties are concerned with the more important and the more permanent matters, but the Executive Department (President) exercises the authority to decide whether a document is to be labeled a treaty or an executive agreement.

Most treaties require implementing legislation by Congress—bills passed by both Houses and signed by the President—but executive agreements are less dependent on this process. However, some treaties are self executing, that is they become completely effective once they are approved by two-thirds of those senators present when the vote is taken.

When a treaty goes into effect, it becomes the supreme law of the land, superior to all State laws and superior to any federal laws then on the books, but subject to federal law later enacted. Thus, a treaty on licensure, compulsory health insurance, disability insurance or any other subject in the medical field would displace all conflicting State laws on the subject. And the only Congressional action needed to put it into effect would be approval of two-thirds of the senators who happen to be on the floor when the treaty is ratified. An executive agreement also would override State law, but whether it would override federal law still is at issue. The Supreme Court once recently avoided a direct decision on the question of executive agreements vs. federal law.

WHAT THE BRICKER AMENDMENT WOULD DO

The Bricker resolution is a proposal to amend the Constitution to limit treaty making to those fields

that we can reasonably assume the framers of the Constitution wanted treaties to deal with. It is also designed to prevent executive-agreement abuses that have developed during the last several decades, because of the worldwide tendency to bring treaty law to bear on more and more domestic questions. Basically, the Bricker resolution would insure that domestic conditions and relations would be handled by normal domestic law, and not by international treaty. It declares, in effect, that a treaty cannot interfere with the States and with the Congress in their right to enact domestic legislation.

Following is the text of the new resolution Senator Bricker introduced in January, 1955, SJRes.1: "Sec. 1. A provision of a treaty or other international agreement which conflicts with this Constitution, or which is not made in pursuance thereof, shall not be the supreme law of the land nor be of any force or effect. Sec. 2. A treaty or other international agreement shall become effective as internal law in the United States only through legislation valid in the absence of international agreement. Sec. 3. On the question of advising and consenting to the ratification of a treaty, the vote shall be determined by yeas and nays, and the names of the persons voting for and against shall be entered on the Journal of the Senate. Sec. 4. This article shall be inoperative unless . . . ratified . . . by the legislatures of three-fourths of the States within seven years . . ."

THE LEGISLATIVE LINEUP

There is almost no argument over sections three and four. There is some feeling that the phrase "or which is not made in pursuance thereof" should be deleted from section one. But the heart of the controversy is section two. Last year the wording of the Bricker amendment was slightly different, but the principle was the same. Before the Senate vote came on February 26, 1954, language suggested by Senator George (D-Georgia) was substituted for section two. The George version sought to make executive agreements (but not treaties) operative as internal law only through Congressional legislation. Thus, it was the George substitute that missed getting the necessary two-thirds Senate majority. The vote was 60 for it, 31 against. Because Senator Bricker believes treaties as well as executive agreements should be subject to established processes of domestic law, he has so stated in the resolution now pending in Congress. Note: The AMA is not committed to any particular wording, but to establishing

some adequate safeguard against treaties and agreements that operate as internal law without first being enacted as internal or domestic law.

SOME EXAMPLES OF INTERFERENCE WITH PROFESSION

Treaty provisions have injected themselves into some medical areas, and under present law they constantly threaten greater interference. Licensure is one example. Until 1923 treaties of friendship and commerce did not attempt to deny States the right to bar aliens from medical and other professional practice. But in 1923 the United States entered into a treaty with Germany that established a new policy on State laws and regulations. For the first time it applied "national treatment provisions" specifically to the professions. This forbids States to bar a person from the practice of medicine solely because of his alienship. In subsequent years nine treaties carrying this "national treatment provision" were ratified. During 1951-1952, three additional treaties with provisions on the practice of professions were submitted to the Senate. Because of mounting objections to the alien provisions, the Senate delayed confirming these treaties. In 1953 the Senate Foreign Relations Committee concluded: ". . . If a State by its own constitutional processes required that an individual seeking to practice a particular profession should be a citizen of the United States, such laws should not be nullified by the national treatment provisions." Subsequently, the committee recommended to the Senate that no treaty carrying the "national treatment" clause be extended.

". . . to professions which, because they involve the performance of functions in a public capacity or in the interest of public health and safety, are State-licensed and reserved by statute or Constitution exclusively to the citizens of the country . . ."

The State Department has agreed to put this reservation in future treaties. So, for the time being, no new treaties will override State licensure provisions, but the older treaties will do so. It should be remembered that this is a "gentlemen's agreement," and that it can be terminated at any time. It is the feeling of the AMA that a more permanent form of safeguard is required. Putting this "gentlemen's agreement" into law would not be the answer, as a later law or a later treaty would take precedence and could restore the alien's right to equal consideration.

Nineteen States have constitutional or statutory

provisions of long standing requiring that to practice certain professions a person must be a United States citizen. Fourteen States require first papers, and ten do not accept foreign trained physicians.

Also held in abeyance, but not permanently disposed of, is an international agreement that could impose a system of national compulsory health insurance on this country. This is the International Labor Organization's Convention on Minimum Standards of Social Security.

The Convention, adopted by the ILO in 1952, covers nine fields: medical care, sickness benefits, unemployment benefits, old age benefits, employment injury benefits, family benefits, maternity benefits, invalidity benefits and survivor benefits. A government is considered to have ratified the Convention if it promises to meet the requirements in three fields.

The medical care section stipulates that a country may qualify as ratifying if it agrees to provide one of the following: a system of compulsory health insurance; private, voluntary health insurance "administered by public authorities under established regulations" set by law; or private, voluntary health insurance administered by insurance companies but under government "supervision." Half the population would have to be covered.

In June, 1954, the State Department forwarded this document to Congress, but with the recommendation that no action be taken, inasmuch as most points were within the jurisdiction of States. Here again, this is not a threat for the time being, but only because of the attitude of present Congress and the present Administration. Another Congress or another administration could push for the ratification of this treaty that could impose a certain degree of socialized medicine without enactment of any domestic law. The treaty is hanging in suspension; it will never expire. It is the contention of the sponsors of the Bricker amendment that protection against this and similar treaty abuses must be established permanently in an amendment to the Constitution.

AMA Supports Hill Bill For Aid to Medical Education

Witnesses for the American Medical Association have supported Senator Hill's bill for federal aid to medical schools for construction and equipment. Drs. F. J. L. Blasingame, a trustee, and Walter S. Wiggins,

associate secretary of the Council on Medical Education and Hospitals, indorsed legislation calling for a \$250 million, five-year program of grants, with the schools paying one-third or one-half. New schools would be entitled to a two-thirds U. S. contribution, but established schools only one-third unless they agreed to increase their freshman enrollment 5 per cent. Dr. Wiggins said that while the AMA is reluctant to indorse new federal grant programs, it believes there is an emergency condition. He also noted that the program is temporary. Dr. Wiggins told the committee that the AMA recommended removing the 5 per cent incentive, which might induce schools to take in more students than they are equipped to educate properly. The Association also urged that the proposed Medical Education Council include six "leading medical authorities." Dr. Blasingame reviewed the AMA's efforts over the last 100 years to improve the quality of medical education. He noted also that while the population of the country has doubled since 1910, enrollment in medical schools has increased more than 125 per cent—and there are no below standard schools.

HR5946—Doctor Draft Extension; Military Medical Scholarships; \$100 Equalization Pay. (Vinson.) The Committee on Armed Services favorably reported HR5946, as amended, to the House. This new bill combines a two-year extension of the Doctor Draft Act, military medical and dental scholarships, and continues the \$100 equalization pay for doctors in the Armed Forces and U. S. Public Health Service.

The committee voted to restrict the total number of scholarships to 5 per cent of the medical school graduates of each year and to require five rather than four years' service for a scholarship of more than a year. On the pay extension issue, the committee recommended continuing the provision as it is now, with all doctors in uniform receiving the extra \$100. The Defense Department had wanted to limit the extra pay to two classes: (a) those with obligation under the doctor draft but not under the regular draft, and (b) those with the double obligation only if they would agree to serve more than the two-year regular draft obligation. The AMA had supported both of these bills. On the pay bill, it urged the straight extension. On the scholarship bill, the Association also proposed a 5 per cent limitation, but based on a somewhat different formula.

Before reporting out the doctor draft extension—which the AMA had opposed in the hearings—the committee made a significant change. It voted to exempt from the special draft any physician or dentist over 35 years of age who previously had applied for a military commission and had been turned down solely because of physical condition. The committee may make further changes in the bill later.

Civil Defense Coordinating Board Formed by President

President Eisenhower on April 9 formed a Civil Defense Coordinating Board with Civil Defense Chief Val Peterson as chairman. The board is designed to draw together all the civil defense activities of federal agencies. Since Federal Civil Defense headquarters were moved from Washington to Battle Creek, Michigan, coordination has not been as good as Mr. Peterson would like it. Heads of these departments have been asked to appoint a top level representative to the board: Health, Education and Welfare; Defense, Commerce, Treasury, Interior, Agriculture, Post Office, and Justice; also Office of Defense Mobilization, Federal Power Commission, Veterans Administration, Atomic Energy Commission and General Services Administration.

Civil Defense Bungled, Hawley Tells Senators

For two months a Senate Armed Services subcommittee had been collecting opinions and facts preparatory to introduction of legislation amending Civil Defense Act. One of its first witnesses was Dr. John C. Bugher, of Atomic Energy Commission, who described effects of radiation injury. In April the Senators heard from Secretary of HEW Hobby. The Senators have a routine account of what her agency is doing against the day disaster might strike. They also heard from Dr. Paul R. Hawley, who delivered a characteristic, no-punches-pulled indictment of present thinking, planning and action.

Dr. Hawley, director of American College of Surgeons, testified that the medical profession generally is unorganized for care of casualties en masse and that siphoning of doctors into the armed forces, should war come, could result in "total disaster, not merely medical disaster," since civilian population would bear brunt of an attack. What needs to

be done, he said, is (1) pool all medical facilities, governmental and private—"The medical potential is too limited to be wasted through dispersion of effort;" (2) enlist participation of medical schools in staffing of emergency hospitals; (3) form an expert group, composed of doctors and laymen, to study all aspects of the problem and formulate a comprehensive program for Congressional approval.

"I know of no group," said Dr. Hawley, a 30 year Army veteran, that has contributed anything to date to planning for civilian medical care in time of war."

Secretary Hobby's testimony was entirely a resume of activities of Public Health Service, Food and Drug Administration, Social Security Administration and Office of Education in fulfillment of civil defense responsibilities delegated to the Department by President Eisenhower.

Defense Department Medical Planning Council Formed

Secretary of Defense Wilson has established a Health and Medical Planning Council under the chairmanship of Dr. Frank B. Berry, Assistant Secretary of Defense (Health and Medical). The council is directed to "actively advise and assist" Dr. Berry in planning and implementing joint programs to provide "adequate health and medical services for the armed forces in an efficient and economical manner." Also on the council are the Assistant Secretaries of Army, Navy and Air Force responsible for manpower and personnel problems. The group expects to hold its first meeting in a few weeks.

As a guide, the Secretary outlined 13 fields of interest for the council, including a number of recommendations made by the Hoover Commission to Congress on February 28. Immediate and long range assignments of the council include studies and recommendations on the following:

1. Assignment to a single department of responsibility for hospital services in certain defined geographic areas.
2. Coordination of military medical and hospital services within U. S. and overseas if practical, aimed at ending overlapping and duplication.
3. Establishment of specific hospitals for all military patients needing highly specialized medical care.
4. Joint staffing of both regular and specialized hospitals from each of the three departments.
5. Determination of ratio of medical officers to military personnel on active duty.
6. Defense Department

role in emergency medical care at time of enemy attack. 7. Provision of medical and hospital care for military dependents both in U. S. and abroad. 8. An "attractive program" to encouraged medical school graduates to join the services. 9. Training programs for interns, residents and other physicians on active duty as well as reservists. 10. Medical aspects of procurement and supply operations in Defense Department. 11. Standardization of medical nomenclature of reports and records used in Defense.

Association Supports New Scientist Deferment Program

The American Medical Association has indorsed in principle HR2847, proposing a new system for deferring scientific students, including medical, from active military duty. The Association's position was outlined in a letter to a House Armed Services subcommittee by Dr. George F. Lull, AMA secretary and general manager. He said, however, "We see little value in requiring a disruption in training or important scientific activities for a period of three months while the deferment determination is made, and recommend that provision be made for application for such deferment sufficiently prior to the date of scheduled induction as to avoid the necessity for such deferment." The association also suggested that a special reserve enlistment, one not requiring an initial period of active duty training, be utilized for men to be deferred from the draft.

At the hearing on the bill, Defense Mobilization Director Arthur S. Flemming objected to the measure, saying that draft officials and the administration's proposed new six month training plan would take care of the problem. In reply, Rep. Carl Hinshaw (R-California), sponsor of the bill, said that the present draft deferment machinery was not functioning properly, as scientists urgently needed in the scientific race with Russia are being inducted and put to work in the Army doing kitchen police work and picking up cigarette butts.

New Woodruff Center Hospital Dedicated

On April 14 the new Woodruff Center Hospital in New Haven was dedicated. Opened under the auspices of the State Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm, this new facility will be devoted to the medical treatment and rehabilitation of those who are

physically disabled by either chronic illness, accident, or the infirmities of age. The building has been named for former Governor Rollin S. Woodruff who was the key figure in its construction when it was part of Grace Hospital.

Opening remarks at the dedication were made by Sidney Shindell, medical director of the Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm. Harry L. F. Locke, chairman of the Commission, made the acceptance speech and remarks were made by Frieda G. Gray, superintendent of the Center; Maxwell Lear, chairman of the Medical Advisory Committee; Creighton Barker, executive secretary of the State Medical Society; and Arthur E. Ebbert, assistant dean of Yale University School of Medicine. Mayor Lee of New Haven delivered the dedicatory address.

In addition to Dr. Lear, the Woodruff Center Medical Advisory Committee includes Bruce R. Valentine, A. J. Tuttles, Michael S. Shea, Walter I. Russell, Everett S. Radermacher, Clement F. Batelli, Joseph J. Lankin, and Allan K. Poole.

New Jersey Doctors Contribute to AMEF

A treasury grant of \$25,000 from the Medical Society of New Jersey will be awarded to the American Medical Education Foundation this year to help support our nation's medical schools. The contribution will be presented to the Foundation during the AMA's 104th Annual Meeting June 6-10 at Atlantic City. Dr. F. M. Clarke, the State's AMEF chairman, notified the Foundation office that the grant was voted by the New Jersey House of Delegates at its annual convention held in April at Trenton.

Total contributions to the AMEF so far in 1955 exceed \$303,685 from 4,225 donors. This figure includes also a grant of \$100,000 from the AMA.

Coming Meetings of the American Medical Association

The following dates and places have been approved for annual and clinical meetings of the Association:

Annual Meetings: 1956—Chicago, June 11-15; 1957—New York, June 3-7; 1958—San Francisco, June 23-27; 1959—Atlantic City, June 8-12.

Clinical Meetings: 1955—Boston, November 29-December 2; 1956—Seattle, November 27-30; 1957—Philadelphia.

FROM OUR EXCHANGES

Postoperative wound infection due to *Staphylococcus aureus* seems to be due, according to Howe, in the main to penicillin resistant *Staphylococcus aureus* (*New Eng. Jour. Med.*, 251:11, pp. 411-416). Therapeutic failures due to this group of organism are becoming more common. The author states that there is growing evidence that the penicillinase-producing, coagulase-positive *Micrococcus pyogenes* (var. *aureus*) is the responsible organism in most cases.

Dr. Howe presents evidence showing that the rate of infection of clean wounds after operation at the Massachusetts Memorial Hospital (and in other hospitals throughout the country) has gradually increased in a stepwise, statistically significant fashion over the past five years despite the prophylactic use of antibiotics. The rate of nasal carriers of these penicillin resistant organisms in the hospital personnel is extraordinarily high.

He offers no method of treatment or prevention. Continued research is indicated. Probably the most important factor in prevention is an awareness on the part of the staff of the nature, magnitude and epidemiology of the problem.

* * * *

Francis J. Braceland, psychiatrist in chief at the Institute of Living in Hartford, expresses concern with the preparation of the medical student today for a proper understanding and treatment of the emotional problems that will be presented to him in his practice ("Psychiatry and the Future of Medical Education," *J. A. M. A.*, 157:16, April 16, 1955, pp. 1377-1381). Dr. Braceland points out the change in disease and in the treatment of disease brought about by the increasing life expectancy. He reiterates W. C. Rappleye's statement that "medicine today is as much a social science as it is a biological science."

Changes are taking place in medical school curricula today in an effort to integrate the approach to the treatment of the ill. It is becoming more and more apparent that one cannot treat man as a problem without giving some attention to the problems of man. This means that the physician of today to be completely trained must have a broad medical

knowledge, scientific and humane in outlook, and must be able to understand the influence of all extraneous factors on the making of symptoms.

Dr. Braceland does not appeal "for more hours for psychiatry set off by itself, but rather for more co-ordination with other branches of medicine or pointing toward the felicitous time when each specialty will be thoroughly familiar with the emotional aspects of the problem and capable of handling them."

* * * *

"The Place of Podalic Version and Extraction in Obstetrics Today" is very well summarized in the *North Carolina Medical Journal* (16:3, March, 1955, pp. 83-88) by a former member of the Connecticut State Medical Society, Deborah C. Leary. Her presentation is well documented with several tables and her conclusions ably summarize the consensus of the majority of well qualified obstetricians today.

"In the average hands, internal podalic version and extraction in single term pregnancy is a formidable procedure, and should be undertaken only when indicated. Suitable indications still remaining are prolapse of the cord at full dilatation and transverse lie at full dilatation.

"Version as a means of delivering the second twin appears a relatively safe and satisfactory procedure.

"Version and extraction should not be undertaken without adequate precautions such as available blood, extra personnel and equipment, so that the likely complications of cervical laceration, postpartum hemorrhage and ruptured uterus can be properly managed. Deep surgical anesthesia should always be used, and the uterus should always be carefully explored after delivery."

* * * *

Prindle *et al.* in "Maternal Hydramnios and Congenital Anomalies of the Central Nervous System" (*N. E. J. Med.*, 252:14, April 7, 1953, pp. 555-561) call attention to the fact that the clinical syndrome known as hydramnios is a manifestation of maternal disease and that, if its etiology is to be discovered, it involves the exploration of a whole system of prenatal deaths and infant defects. The task is so

complex it calls for the combined efforts of many disciplines of both medicine and public health.

* * * *

Kotin at the 3rd National Air Pollution Symposium held in Pasadena, California in April, 1955 described smog as the greatest single cause of lung cancer. Kotin and a research team have conducted experiments for more than four years with thousands of animals under a U. S. Public Health Service grant at U. S. C. Medical School and the Los Angeles County General Hospital. The animals were subjected to artificial smog created by gasoline vapors and fumes from gasoline and diesel engines.

According to Kotin the study showed that smog "has a prolonged cumulative effect" as a tumor inducer. The pollutant which is the irritant causing cancer is at least one type of hydrocarbon in the oxidized state. Kotin and his coworkers could not find smog to be otherwise deleterious to health, that is, no consistent biological changes in the respiratory systems of the test animals were found.

* * * *

Strong (*Canadian Med. Assoc. Jour.*, 72:4, pp. 247-252) re-emphasizes the fact that rehabilitation is not a panacea that can be compressed into a hypodermic syringe. It is a complex and extensive process that involves directly or indirectly all medical specialties and auxiliary services.

The need for rehabilitation is enormous, embracing the entire nation and reaching into every level of society. It is essentially a health problem and should be a first responsibility of the medical profession. Rehabilitation offers a challenge so broad in scope that there is a part to be played by everyone. It is not something to be resorted to when all other measures have failed, but is an active process that should commence in the hospital as soon as the patient has recovered from the acute phase of his illness or the immediate officers of his accident.

* * * *

The incidence of left duodenal hernia, according to Murray (*Canadian Med. Assoc. Jour.*, 72:4, pp. 263-267), is fairly constant in relation to other intra-abdominal hernia. Of 467 cases of intra-abdominal hernia reported in the literature up to 1939, 185 (53 per cent) were paraduodenal—138 left and 48 right.

The symptoms of duodenal hernia are variable and may occur at any age. The onset may be sudden and

the symptoms those of complete small bowel obstruction. A number of patients provided a history of intermittent colic with or without vomiting, and a sense of heaviness or periods of distension of the abdomen for a long time. Radiography is an important aid in diagnosis, particularly in demonstrating limited motility of the small bowel loops.

The author expresses the opinion that more cases should be diagnosed preoperatively when there is an increased awareness of the possibility of the condition.

* * * *

"Does the Modern Pace Really Kill" is a question asked by Shepard (*Jour. Amer. Geriatric Soc.*, III: No. 2, pp. 139-145). Dr. Shepard notes that there has been a consistent and gratifying reduction over the past twenty years in the death rate of males over the age of 45 years. However, despite this overall reduction, there has been a considerable increase in the death rate from coronary disease and from respiratory cancer in the past twenty years in this age group. There are, according to the author, 10 coronary deaths for one respiratory cancer death.

The individual's reaction to work, rather than the work per se, may be the most important factor in assaying and preventing stress disorders.

Dr. Shepard suggests that fruitful lines of study and action are (1) better methods of selecting and training executives, (2) identifying and quickly relieving the individual who is peculiarly susceptible to stress, (3) more and better medical guidance in all industries, and (4) fuller utilization of the newer knowledge on improving emotional balance and interpersonal relations.

Editorial comment: This on paper is a sound program. The trouble seems to be to obtain the consent of the patient. Most top notch executives refuse to stop or even change their way of living until the main damage is complete. Even when an accident occurs the chances are that they will be doing what they want to do as soon as the doctor has passed around the next corner. That is the way they are made and it is a principal reason for their success.

* * * *

Klatskin in a long detailed article reviews the present status of leptospirosis, Weil's disease (*Yale Jour. Biol. & Med.*, 27:4, pp. 243-266). There have been isolated six distinct strains of leptospirae that are implicated as sources of human infection. The infection as it is produced in man invariably follows

direct or indirect contact with animals that serve as the natural reservoir of leptospirae. The various leptospiral strains tend to fall into distinctive patterns but this is by no means constant and most strains are potentially capable of producing the same lesion. Thus any given strain may fail to produce localizing signs, or may give rise to hepatitis, nephritis or meningitis, either alone or in combination.

Leptospiral infections in man are almost invariably the consequence of close contact with animals or their urine. The rat is responsible for most cases of Weil's disease. The dog is capable of transmitting the disease but does so rarely. Certain occupations favor infection, among which may be mentioned butchers, fish cleaners, sewer workers, plumbers, garbage handlers, dock workers, etc. Swimming and accidental immersion in rat-contaminated stagnant bodies of water constitute another source of acquiring Weil's disease.

The incubation period is from 7 to 13 days. With the onset of symptoms *L. Icterohaemorrhagiae* appear in the blood in large numbers and are spread to most or all of the tissues of the body. At the end of a week the leptospirae have usually vanished from the blood and can seldom be found in any tissue but the kidney.

The important thing in diagnosis is an awareness of the wide distribution of the disease and familiarity with its protein manifestations. During the first week an attempt should be made to isolate leptospirae from the blood by animal inoculation or culture. At the same time a specimen of serum should be examined for leptospiral agglutinins and/or complement-fixing antibodies. These reactions are seldom demonstrable in significant titre before the end of the second week but this first determination serves as a base line for subsequent tests which should be carried out at weekly intervals.

Only immune serum of animal origin has proved effective, and then only if given before the appearance of jaundice. Antibiotic therapy results have been equivocal and are still being investigated. Penicillin is lethal to leptospirae in culture and protects guinea pigs against death if given within 18 hours of infection. It is completely ineffective if administered following the appearance of symptoms. The results of antibiotic therapy in man have been on the whole ineffective. The author suggests the employment of massive doses of penicillin early in the course of Weil's disease, at least until such time

as the results of antibiotic therapy have been more fully evaluated. The management of Weil's disease is much like that of any other acute systemic infection. The kidney function should be closely watched, and, when renal insufficiency supervenes, attention should be directed toward regulation of fluids, electrolyte and nitrogen balance. Blood loss may be an important consideration in severe infections and should be replaced. There is no evidence that the diet has any influence on the hepatic lesions in leptospirosis, and the high protein intake often recommended in liver disease may be distinctly harmful if renal insufficiency is present.

Vaccines prepared from heat-killed or phenol-treated leptospirae are effective immunizing agents. They are used to some extent in areas where the disease is prevalent.

* * * *

Braude reviews at length the epidemiology and treatment of brucellosis (*G. P.*, XI:3, pp. 75-84). Three species of brucella have been known to infect humans. In the United States the usual cause is *Br. abortus*, a cattle-borne organism that enters the human body by direct contact or less often by ingestion of unpasteurized dairy products. Exceptional growth requirements and the small number of organisms present make it difficult to recover the causative agent in blood culture. Many blood cultures are usually necessary. The diagnosis of brucellosis can be made with certainty only when the specific organism is isolated by culture. The agglutination test is important in the diagnosis of brucellosis. The skin test has been widely used but is believed to be of no value. The sedimentation rate is variable but is elevated in about one-half the cases. A high leukocyte count makes the diagnosis of brucellosis unlikely. There is commonly some anemia which may continue for weeks or months. There is a good deal of natural defense against brucellosis, and the disease is usually self limited.

Treatment with tetracycline drugs is quite effective. Streptomycin has been used with some dramatic cures. However, it is usually given in combination with the tetracycline derivatives or sulfadiazine. In addition to specific antibiotic therapy it is important that the patients be reassured, for they are often emotionally shaken by a prolonged illness such as brucellosis. Bed rest ranks as an essential in the treatment of brucellosis.

ANNUAL REPORTS
OF THE CONNECTICUT STATE MEDICAL SOCIETY

1954-1955

REPORT OF THE TREASURER

A detailed statement of the financial activities of the Society for 1954, prepared by the firm of Seward & Monde, is printed herewith in the agenda.

The general financial status is very favorable. It is considerably better than had been expected. The 1954 budget was tight; estimated income not allotted was \$92.68.

During the year the Council increased the allotment to Public Relations by \$1,400. and Committees by \$225. The actual expenditure for budgeted items was \$101 under the budget.

The General Fund surplus increased more than \$5,500. in spite of the fact that Scholarships of \$2,500. were taken from surplus.

The Annual Meeting Fund increased more than \$1,800.

Special Funds were essentially unchanged.

Net income from dues was approximately \$67,000., \$1,700. over the budget figure, and \$2,300. more than preceding year.

The Journal's record is creditable. Income exceeded the previous year by \$7,200. Expenses were \$2,500. more. Excess of expenses over income of \$2,824. compare with a figure over \$7,000. in 1953.

The grand total (Statement of Assets and Liabilities) of \$220,023.75 represents the following assets:

\$ 95,401.00.....	Cash
27,966.44.....	Securities
93,523.88.....	Building and Equipment
3,132.43.....	Accounts Receivable
<hr/>	
\$220,023.75	

This amount is \$9,682. above the 1953 figures.

Respectfully submitted,
Frank H. Couch, M.D.

Seward and Monde
Certified Public Accountants
205 Church Street
New Haven 10, Connecticut

The Connecticut State Medical Society
New Haven, Connecticut

We have examined the balance sheet of The Connecticut State Medical Society as of December 31, 1954 and the related statements of income and surplus for the year then ended, have reviewed the system of internal control and the accounting procedures of the Society, and without making a detailed audit of the transactions, have examined or tested accounting records of the Society and other supporting evidence by methods and to the extent we deemed appropriate.

General Fund:
Cash in banks, reconciled and confirmed by direct correspondence with the depositories, is accounted for as follows:

Commercial accounts:	
The Second National Bank and Trust Company—Journal collections	\$4,937.79
The Second National Bank and Trust Company—Journal revolving fund....	3,600.00
The Second National Bank and Trust Company—Secretary's office revolving fund	4,000.00
The Second National Bank, Trust Department:	
Income cash account.....	7,476.25
Principal cash account.....	74.29
	<hr/> \$20,088.33

Savings accounts:	
Connecticut Savings Bank of New Haven—Journal	\$ 5,115.63
Connecticut Savings Bank of New Haven	12,229.31
National Savings Bank of New Haven	10,530.39
Chelsea Savings Bank of Norwich.....	10,273.81
	<hr/> 38,149.14
	<hr/> \$58,237.47

Petty cash—Journal office.....	5.00
Total	\$58,242.47

The Second National Bank of New Haven confirmed directly to us that as of December 31, 1954 they held the following securities as agent for the Treasurer of The Connecticut State Medical Society:

United States Treasury Bonds:

FACE VALUE	RATE AND MATURITY	BOOK VALUE	MARKET VALUE
\$7,000	2½ % 1969	\$6,795.73	\$6,930.00
5,000	2½ % 1970	5,000.00	4,946.88
3,000	2½ % 1971	2,979.11	2,968.13
2,000	2½ % 1957	2,000.00	2,051.88

Province of Canada Bonds:

3,000 Province of Saskatchewan 3½ % due February 1, 1966	3,021.60	3,052.50
3,000 Province of Nova Scotia 3½ % Deb. due March 15, 1964	2,988.75	3,180.00

Stock:

50 shares Celanese Corp. of Amer. Ser. A 4½ % cum. preferred	5,181.25	3,975.00
Total	\$27,966.44	\$27,104.39

Dues receivable of \$1,412.50 are segregated by counties as follows:

COUNTY	AMOUNT
Fairfield	\$ 300.00
Middlesex	50.00
Litchfield	25.00
New London	100.00
Hartford	600.00
New Haven	312.50
Tolland	—
Windham	25.00
Total	\$1,412.50

Accounts receivable—Journal of \$1,155.31 consist of 1954 advertising accounts which were paid in 1955.

Accounts payable—Journal of \$467.44 represents amounts due for printing expenses.

The following is a comparison of budgeted and actual general expenses:

	BUDGET	ACTUAL	ACTUAL OVER OR (UNDER BUDGET)
Secretary's office	\$29,520.32	\$28,745.19	(\$ 775.13)
Treasurer's office	2,845.00	2,460.89	(384.11)
General and contingent	5,525.00	5,519.94	(5.06)
Public relations	14,672.00	14,908.13	236.13
Committee allotments ..	2,975.00	1,826.61	(1,148.39)
Building maintenance	6,985.00	7,506.38	521.38
Journal	34,660.00	36,113.66	1,453.66
Total	\$97,182.32	\$97,080.80	(\$ 101.52)

Annual Meeting Fund:

Cash of \$14,216.97 in the New Milford Savings Bank and a balance of \$2,489.82 in The Union and New Haven Trust Company was confirmed directly.

Gurdon W. Russell Fund:

Cash of \$2,036.44 in the Mechanics Savings Bank, Hartford, was confirmed by direct correspondence.

The Second National Bank of New Haven confirmed directly to us that as of December 31, 1954 they held the following fund securities as Agent for the Treasurer of the Connecticut State Medical Society:

FACE VALUE	VALUE DECEMBER 31, 1954 PER BOOKS	MARKET
\$691.12 New York, New Haven and Hartford Railroad Co. 4%—due 2007.....	\$ 458.00	\$ 545.98
\$985.61 New York, New Haven and Hartford Railroad Co. 4½ %—due 2022....	338.00	707.18
\$523.27 New York, New Haven and Hartford Railroad Co. 5% conv. pfd. stk.—Series A	134.00	340.13
\$1,000.00 Boston and Albany Railroad Company, 4¼ % improvement bonds, due August 1, 1978.....	820.00	810.00
\$5,000.00 U. S. Treasury bonds, 2¼ % due 1959	5,000.00	5,042.19
Totals	\$6,750.00	\$7,445.48

O. C. Smith Fund:

We confirmed the principal and income cash of \$1,240.02 in the Mechanics Savings Bank, Hartford, by direct correspondence.

Building Fund:

During the year funds have been transferred from the general funds to the reserve for depreciation. Cash of \$7,385.32 was confirmed directly to us by the Connecticut Savings Bank of New Haven.

Clinical Congress:

Cash of \$2,749.75 in the New Haven Savings Bank and a balance of \$176.33 on deposit at The Second National Bank of New Haven was confirmed directly by the depositaries.

The Secretary's office has acted as collection agent for The American Medical Association's dues and The American Medical Education Foundation for the year 1954. At December 31, 1954 there was on deposit \$87.50 representing collections during the month of December not remitted to The American Medical Association. This amount does not appear on the attached statement.

In our opinion, the accompanying balance sheet and statements of income and surplus present fairly the position of The Connecticut State Medical Society at December 31, 1954, and the results of its operations for the year, in conformity with generally accepted accounting principles

applied on a basis consistent with that of the preceding year.

Seward & Monde,
Certified Public Accountants

New Haven, Connecticut
March 5, 1955

Balance Sheet, December 31, 1954

GENERAL FUND

ASSETS

Cash	\$58,242.47
Investments (market value \$27,104.39)	27,966.44
Dues receivable—1954	1,412.50
Accounts receivable—Journal advertising	1,155.31
Automobile emblems on hand	246.00
Prepaid insurance	318.62
	<hr/>
	\$89,341.34

LIABILITIES

Accounts payable:	
Journal	\$ 467.44
Accrued commissions—1954 dues	8.75
Surplus	88,865.15
	<hr/>
Total	\$89,341.34

ANNUAL MEETING FUND

ASSETS

Cash	\$16,706.79
Prepaid expenses—1955 annual meeting	113.88
	<hr/>
Total	\$16,820.67

LIABILITIES

Deferred receipts—1955 annual meeting	\$ 2,400.00
Surplus	14,420.67
	<hr/>
Total	\$16,820.67

SPECIAL FUNDS

ASSETS

Gurdon W. Russell Fund:	
Cash	\$ 2,036.44
Investments (market value \$7,445.48)	6,750.00
	<hr/>
	\$ 8,786.44
O. C. Smith Trust Fund:	
Principal cash	\$ 1,000.00
Income cash	240.02
	<hr/>
	1,240.02

Building Fund:

Land	\$12,270.31
Building and equipment	81,253.57
	<hr/>
	\$ 93,523.88
Cash—savings account (funded re- serve for depreciation)	7,385.32
	<hr/>
	100,909.20

Clinical Congress:

Cash	2,926.08
	<hr/>
Total	\$113,861.74
	<hr/>
Grand total	\$220,023.75

LIABILITIES

Gurdon W. Russell Fund—capital	\$ 8,786.44
O. C. Smith Trust Fund—capital	1,240.02
Building Fund:	
Reserve for depreciation	\$ 7,385.32
Capital	93,523.88
Clinical Congress—capital	2,926.08
	<hr/>
Total	\$113,861.74
	<hr/>
Grand total	\$220,023.75

Statement of Income and Surplus General Fund

Year Ended December 31, 1954

Income:

Dues earned	\$67,250.00
Less, Commissions paid	291.20
	<hr/>
	\$66,958.80
Interest and dividends on investments	1,788.81
Gain on sale of securities	131.40
Sale of automobile emblems	73.50
Rental income	2,305.00
Income from collection of AMA assessments	583.13
	<hr/>
Gross income	\$71,840.64

Expenses:

Secretary's office	\$28,745.19
Treasurer's office	2,460.89
General	4,330.38
Contingent fund	1,189.56
Public relations	14,908.13
Committee allotments	1,826.61
Building maintenance	7,506.38
	<hr/>
	60,967.14
Excess of general income over expenses	\$10,873.50
Less, Excess of expenses over income—Journal operations	2,824.96
	<hr/>
Net income	\$ 8,048.54

Surplus, January 1, 1954.....	\$83,316.61
Less, Appropriations out of surplus:	
Scholarships	2,500.00
	<u>80,816.61</u>
Surplus, December 31, 1954.....	\$88,865.15

Details of Expenses

Year Ended December 31, 1954

Secretary's Office:

Personal Services:

Executive secretary	\$14,000.00
Annuity for executive secretary.....	999.94
Administrative assistant	5,000.00
Secretary	2,940.00
Secretary	2,215.00
Stenographer	1,661.80

\$26,816.74

Less, Transferred from:

Treasurer's office	\$ 750.00
Public relations	1,200.00
Collection AMA dues.....	216.87

2,166.87
\$24,649.87

Executive secretary expense.....	1,070.57
Executive secretary expense—prior years.....	710.32
Office supplies	299.95
Printing and postage.....	750.61
Automobile expense	626.11
Telephone and telegraph.....	229.04
Bank charges	18.92
Publications	20.60
Social security taxes.....	280.11
Miscellaneous	89.09

Total\$28,745.19

Treasurer's Office:

Personal service	\$ 750.00
Auditors	570.00
Fiscal agent	356.00
Postage and printing—(collection of society dues)	254.58
Postage and printing—(collection of AMA dues)	500.00
Miscellaneous	50.31

Total\$ 2,460.89

General:

Chairman of Council.....	\$ 300.00
President of Society.....	300.00
Council	716.69
Delegates to AMA convention.....	2,695.39
Blue Cross premium for employees.....	318.30

Total\$ 4,330.38

Contingent Fund:

Advisory Committee with the State Welfare Department	\$ 77.02
Conference of Presidents.....	75.00
Connecticut Health League.....	137.40
Semi-annual meeting—House of Delegates.....	344.12
Presidents pictures	42.36
Joint Committee—Bar Association.....	45.00
Crash Research Committee.....	42.20
Revision Committee—C.M.S. fees.....	51.25
Printing meeting notices.....	72.00
Reprints—"Malpractice and The Physician".....	31.25
Scholarship expenses	47.48
Attorney fees	178.01
Miscellaneous	46.47

Total\$ 1,189.56

Public Relations:

Personal services—director	\$ 8,000.00
Printing and postage.....	\$ 1,549.51
Publications	39.75
Clipping service	240.00
Telephone and telegraph.....	184.82
AMA Educational Campaign.....	719.06
Travel and expense—AMA meetings....	515.41
Meetings of public relations committee	609.41
Clerical assistance	1,200.00
Health Exhibits—County Fairs.....	1,052.50
Television productions	619.84
Supplies and miscellaneous.....	105.83
Social security taxes.....	72.00

6,908.13

Total\$14,908.13

Committee Allotments:

Public health	\$ 97.07
National legislation	280.73
Pharmaceutical—joint	90.19
Medical care veterans.....	239.96
Council of New England State Medical Societies	230.04
Rural health	18.77
Mental health	180.40
Cancer coordinating committee.....	55.17
Coop. committee—Yale	48.20
Food, drugs, cosmetics, and devices.....	59.00
Honorary members	7.00
Hospital committee	43.51
Medical education and licensure.....	259.20
Maternal Mortality, Morbidity.....	25.00
Dental conference	192.37

Total\$ 1,826.61

Building:

Taxes	\$ 1,737.02
Janitor	960.00
Insurance	392.48

Electricity, gas and water.....	748.58
Fuel	346.04
Care of grounds.....	777.13
Depreciation and obsolescence.....	1,400.00
Supplies	149.31
Telephone	881.10
Repairs, replacements and maintenance.....	114.72
Total	\$ 7,506.38

Statement of Journal Operations
Year Ended December 31, 1954

<i>Income:</i>	
Advertising (net of commissions).....	\$26,244.93
Subscriptions	1,123.63
Reprints	5,338.00
Electrotypes	461.60
Single copy	9.50
Roster book	82.50
Miscellaneous	28.54
	<u>\$33,288.70</u>
<i>Expenses:</i>	
Personal services:	
Managing Editor	\$ 3,000.00
Secretary	2,860.00
Advertising agent	1,517.69
	<u>7,377.69</u>
Manufacturing cost:	
Printing	\$22,453.28
Postage and handling.....	600.54
Electrotypes	888.19
Reprints	3,929.46
	<u>27,871.47</u>
Other:	
Telephone	\$ 47.60
Office expense	317.34
Sales tax	24.00
Clerical assistance	60.00
Travel expense—editor	264.53
Social security taxes.....	117.20
Publications	27.50
Miscellaneous	6.33
	<u>864.50</u>
	<u>36,113.66</u>
Excess of expenses over income.....	\$ 2,824.96

<i>Expenses:</i>	
Program Committee and Local Com- mittee on arrangements.....	\$ 97.14
Telephone	74.25
School rental and janitor service.....	535.50
Printing and postage.....	1,642.86
Badges	72.28
Exhibit decorator, rentals and equip- ment	1,127.30
Meeting operating expenses.....	232.35
House of delegates.....	434.90
Lunches and dinner expense (guests and entertainment)	498.89
Extra help, clerical, police, firemen.....	674.00
Speakers and visiting delegates.....	890.77
Council dinner	529.88
Attendance of scholarship recipients....	89.50
Miscellaneous	4.76
	<u>6,904.38</u>
Excess of meeting income over meeting expenses	1,395.62
Surplus, January 1, 1954.....	\$12,602.47
Add, Interest earned on savings account	422.58
	<u>13,025.05</u>
Surplus, December 31, 1954.....	\$14,420.67

Statement of Capital
Special Funds
Year Ended December 31, 1954

GURDON W. RUSSELL FUND	
Balance, January 1, 1954.....	\$10,064.62
Add, Interest and dividends on savings accounts and bonds	328.98
Proceeds from sale of equipment.....	50.00
	<u>\$10,443.60</u>
Deduct, Disbursements for sundry items of equipment and furniture.....	1,657.16
Balance, December 31, 1954.....	\$ 8,786.44
O. C. SMITH FUND	
Balance, January 1, 1954.....	\$ 1,209.62
Add, Interest received on savings accounts.....	30.40
Balance, December 31, 1954.....	\$ 1,240.02
BUILDING FUND	
Balance, January 1, 1954 and December 31, 1954....	\$93,523.88
BUILDING FUND—RESERVE FOR DEPRECIATION	
Balance, January 1, 1954.....	\$ 5,831.76
Add, Interest earned.....	153.56
Contribution from general funds.....	1,400.00
	<u>7,385.32</u>
Balance, December 31, 1954.....	\$ 7,385.32

Statement of Income and Surplus
Annual Meeting Fund
Year Ended December 31, 1954

<i>Income:</i>	
Exhibits	\$ 8,300.00

Statement of Income and Capital
Clinical Congress Fund
Year Ended December 31, 1954

Income:

Registrations\$ 1,310.00

Expenses:

Committee meetings\$ 29.46
 Speakers 956.66
 Badges 26.25
 Telephone 7.04
 Printing and postage..... 509.43
 Rentals 149.53
 Clerical assistance 73.37
 Miscellaneous 13.89

1,765.63

Excess of expenses over income.....\$ 455.63

Surplus, January 1, 1954.....\$ 3,487.90

Add, Interest earned on savings account 83.43

\$ 3,571.33

Deduct, Expense in connection with
 special survey 189.62

3,381.71

Surplus, December 31, 1954.....\$ 2,926.08

MEMBERSHIP REPORT OF THE SECRETARY

FAIRFIELD COUNTY

Membership—January 1, 1954.....739

New Members 64

Less:

Deaths 6

Resignations, transfers, non-payment dues, etc...18 24

—

Net Gain 40

Membership—December 31, 1954.....779

HARTFORD COUNTY

Membership—January 1, 1954.....871

New Members 53

Less:

Deaths 4

Resignations, transfers, non-payment dues, etc...17 21

—

Net Gain 32

Membership—December 31, 1954.....903

LITCHFIELD COUNTY

Membership—January 1, 1954.....122

New Members 5

Less:

Deaths 1

Resignations, transfers, non-payment dues, etc...2 3

—

Net Gain 2

Membership—December 31, 1954.....124

MIDDLESEX COUNTY

Membership—January 1, 1954..... 94

New Members 10

Less:

Deaths 1

Resignations, transfers, non-payment dues, etc... 0 1

—

Net Gain 9

Membership—December 31, 1954.....103

NEW HAVEN COUNTY

Membership—January 1, 1954.....802

New Members 70

Less:

Deaths 8

Resignations, transfers, non-payment dues, etc...15 23

—

Net Gain 47

Membership—December 31, 1954.....849

NEW LONDON COUNTY

Membership—January 1, 1954.....159

New Members 17

Less:

Deaths 1

Resignations, transfers, non-payment dues, etc... 5 6

—

Net Gain 11

Membership—December 31, 1954.....170

TOLLAND COUNTY

Membership—January 1, 1954..... 15

New Members 1

Less:

Deaths 0

Resignations, transfers, non-payment dues, etc... 0 0

—

Net Gain 1

Membership—December 31, 1954..... 16

WINDHAM COUNTY

Membership—January 1, 1954..... 61

New Members 3

Less:

Deaths 0

Resignations, transfers, non-payment dues, etc... 0 0

—

Net Gain 3

Membership—December 31, 1954..... 64

ASSOCIATE MEMBERS

January 1, 1954..... 11

New Members 1

—

Associate Members—December 31, 1954..... 12

Total Society Membership—January 1, 1954.....2,863

New Members 223

Total Membership—December 31, 1954.....3,086

Less:

Deaths 21

Resignations, transfers, non-payment dues, etc... 57 78

—

TOTAL SOCIETY MEMBERSHIP—December 31, 1954.....3,008

Net Gain for year145

TOTALS	
Fairfield	779
Hartford	903
Litchfield	124
Middlesex	103
New Haven	849
New London	170
Tolland	16
Windham	64
	3,008
Associate Members	12
	3,020

REPORT OF MANAGING EDITOR OF
CONNECTICUT STATE MEDICAL JOURNAL

Stanley B. Weld, *Chairman*

Hugh J. Caven	Marshall Pease
Mark A. Hayes	Charles H. Peckham
Samuel D. Kushlan	Clair Rankin
Thomas Mackie	Allan J. Ryan
Ward McFarland	Morris S. Shea
Harold S. Burr— <i>Associate Member</i>	

With the resignation of Dr. Thoms as literary editor, the managing editor assumed the duties of the former in addition to his own. The composite duties of the two seem to have steadily increased during the year like the proverbial snowball but by relinquishing some of the more frivolous pastimes it has been possible to keep abreast of the demands made by the *Journal*. Dr. Barker has supplied valuable assistance in two directions, viz., by writing some of the editorials for which his experiences as secretary of the Society and of the Medical Examining Board have made him exceptionally qualified, and by continuing to secure manuscripts from speakers who appear before various medical organizations in our State.

Following the recommendation of a special committee the House of Delegates, at the last annual meeting, very wisely increased the size of the Editorial Board to include a good representation from the specialties and to represent in so far as possible different sections of the State. These new Board members have been of invaluable assistance in the selection of manuscripts and as counsel to the editor. It would be doing a great injustice to fail to give public recognition to the value of the office secretary, Mrs. Feriola. Her faithfulness and steadily increasing proficiency have contributed much to the *Journal* to which the reader doubtless never gives a thought.

This has been the most successful year financially that the *Journal* has experienced in a long time. The cost to the Society has been less than one dollar per member. This may be attributed chiefly to an increase in advertising, both from our local representative and from the State Journal Ad-

vertising Bureau of the American Medical Association. As chairman of the latter's advisory committee for ten years, it has been a source of great satisfaction to observe the capable management of the Bureau resulting in increased returns to the thirty-three State journal members. Our local representative is contributing to our increased advertising and should be kept in mind by all our readers when prospective advertisers suggest themselves to them.

During the year a total of 76 scientific manuscripts have been published; 53 by our own members and 23 by physicians outside the State. In addition there have been 14 articles by laymen of various kinds, some relating directly to medicine, others to economic problems of interest to physicians.

Progress in Clinical Medicine and the Historian's Note Book have appeared in nine issues. There has been but one clinicopathological conference reported. Eleven Letters to the Editor have been published, more than twice the number that appeared during the previous year.

This year the editorials have numbered 76. G. B. from the West Coast continues to maintain his interest in Connecticut medicine with frequent pertinent editorials. The President's Pages have produced many favorable comments. "From Our Exchanges" continues to show the laborious work of one of the Editorial Board, Marshall Pease. The section entitled Public Relations is supplied by Mr. James G. Burch, director of public relations for the Society. To him the *Journal* also owes a debt of gratitude for substituting in the make-up when the editor is unavoidably out of reach. The Woman's Auxiliary does not miss an issue. The County News Editors for the most part are doing a good job. Tolland County continues to remain unheralded and unsung. Fourteen obituaries appeared during 1953 and reviews of 30 books were published.

The Convention Issue in April featured the Hartford Hospital which was celebrating its centennial year and by invitation occupied a portion of the program of the annual meeting convened in Hartford. Papers presented at this particular session as well as addresses delivered at the annual dinner of the Society appeared in the December issue.

The *Journal* is rapidly becoming of age. The fact that it is sought by medical societies and medical publications in England, Denmark, Finland, Italy, India, South Africa and South America is a source of some satisfaction. The increase in manuscripts submitted by our own members gives evidence of local interest. As a house organ for the Society the *Journal* has its value; but as a means of scientific expression for our members it should be invaluable, particularly if the product is couched in good English and affords a real contribution to medical literature. It has been said by one of the 18th century writers:

"You write with ease to show your breeding,
But easy writing's curst hard reading."

Respectfully submitted,
Stanley B. Weld

REPORT AND INFORMAL REMARKS OF THE CHAIRMAN OF THE COUNCIL

The minutes of the Council meetings have been published in the JOURNAL of the Connecticut State Medical Society, so a detailed report of the activities of the Council will not be given at this time. The attendance of the members of the Council at the meetings has been very good and I wish to express my appreciation for their diligence in handling the problems of the Council.

As you will note in your agenda, under new business, there is a recommendation from the Council on medical school scholarships and another recommendation for a retirement program for the employees. These will be discussed at the proper time on the agenda.

Just a superficial examination of the reports of the many committees of the Connecticut State Medical Society that are published in the agenda will indicate that Connecticut medicine still has many problems, and it is trying to solve them.

You undoubtedly have read the reports in the agenda of the Committee on Hospitals, also the Committee on Third-Party Payments for Medical and Ancillary Non-surgical Services and the report of the Committee on National Legislation, especially as to health reinsurance, the extension of the Hill-Burton bill for diagnostic centers. I believe these few examples are sufficient to indicate that there is still a keen interest in the economic aspect of medical care, not only by physicians, but also by non-physicians.

There are still groups in this country who are of the opinion that there should be some type of a national health scheme; there are other groups who believe that medical care should be handled by nonprofit groups, such as hospitals or labor unions; there are other people who believe the answer is in a Kaiser type plan, and others believe that the answer is in commercial insurance with an indemnity type plan.

It must be evident that in all of these plans the physicians lose control of the economic aspect of medical care. We also know who controls your pocketbook controls you, and loss of control of the economic aspect of medical care could also mean loss of control of scientific medicine.

We physicians are humanitarians, but in order to work in a materialistic world it is necessary to be a practical humanitarian. Social change is like a river, you cannot stop it but you can control it by dams, dikes, and bridges, so it can serve a useful purpose.

We are today more than ever before facing the fact that third parties are going to pay for the major part of the expenses of our patients. Therefore, we must decide what is best for our patients and for ourselves.

When the Connecticut State Medical Society was definitely faced with the problem of National Health Insurance in 1948, it decided after long discussion that the best method was a nonprofit medical care plan under the auspices of the Society. Connecticut Medical Service was created as a result of this decision.

I would like to quote two paragraphs from the report of the Committee on Prepaid Medical Service which was

adopted by the House of Delegates' on December 9, 1948:

"It will be the purpose of Connecticut Medical Service, Inc., to facilitate through group prepayment methods and low-cost, non profit operation acceptable means to secure for the working population of Connecticut insurance against the cost of certain medical services. It will include all possible and insurable medical care which is commensurate with the ability of the large segment of low-income people to pay for in premium form.

"It is recognized that the inclusive income level defining the area within which the program will provide complete service coverage should be such as to cover at least one-half of the working population and their families."

How well have the purposes been accomplished as defined by the Connecticut State Medical Society? At this time CMS has 893,000 enrolled members; it has paid approximately 450,000 claims and over \$23,000,000; 50 per cent of these claims were for Service Benefits and 11 per cent were provided Service Benefits even though the subscriber indicated that he was not entitled to them.

Two major contract changes and many minor changes have been made. In the beginning the covered services were surgery and obstetrics, and it has now been increased to cover in-hospital medical care and x-rays in physicians' offices on a deductible basis. Enrollment regulations have been changed many times. One of the noticeable changes was to allow the self employed to buy coverage directly.

This short summary indicates that Connecticut Medical Service has fulfilled the purpose as defined by the Connecticut State Medical Society and Connecticut medicine can justly be proud of its creation.

How has this been accomplished?

1. By the support of the Participating Physicians who now number 2,400.
2. By the support of the county medical associations and the Connecticut State Medical Society.
3. By the work of the Board of Directors of Connecticut Medical Service (six nonphysicians and six physicians), the Professional Policy Committee and the administrative staff who accepted the responsibility given to them by Connecticut medicine and have had the courage to exercise the authority commensurate with the responsibility.

All of this has not been accomplished without criticisms. Some physicians have been so critical that they are not Participating Physicians. Connecticut Medical Service is known as the "Doctor's Plan" and every physician should feel free to make constructive criticisms and suggestions and question the policies of its operation, if by so doing, it will make it a better plan. However, it must be remembered that if you are not closely associated with an undertaking as complex as this is and exposed to its many facets, it is difficult to have the broad view necessary to make constructive changes.

Connecticut Medical Service has shown that it is an alert, aggressive and forward-looking enterprise. As soon as one change is made, another change is under consideration. It needs no mandate from the Connecticut State Medical Society or any group of physicians in order to make changes. It will incorporate all gainful changes as rapidly

as is consistent with the purposes of the plan as originally stated by the Connecticut State Medical Society. It is probable that mistakes have been made as must be expected in a project as great as this. We believe they have been corrected and the plan improved.

In Connecticut Medical Service, Connecticut medicine has created the best voluntary method of prepaying the costs of medical care without the intercession of an indifferent or perhaps an antagonistic third party. At present 44 per cent of the Connecticut population are relying on the Participating Physicians for continuation and expansion of this means to pay for medical service and our public responsibility surpasses all else.

In 1948 the creation of Connecticut Medical Service was important to Connecticut medicine on account of the threat of "socialized medicine." Today it is even more important than in 1948 because:

1. A large percentage of our residents in Connecticut are dependent upon the plan.
2. The pattern has been set for third-party payments.
3. It is the only method of providing third-party payments with physicians making the policies.
4. While the threat of "socialized medicine" is in the background, there are still many groups in this country who are desirous of changing the time-honored private practice of medicine.

Connecticut Medical Service is the strong right arm of the Connecticut State Medical Society in the struggle to establish good relations with the public of Connecticut and against the encroachment of nonphysician groups in the practice of medicine.

Gentlemen, that completes my formal report. Informally, I would like to make one or two remarks on this subject.

Some fifteen, almost twenty, years ago there were some forward-looking men in medicine who could see that there had to be a change in the economics of medical care. Some of these men were in Connecticut. There are a few of them here in the House today: Oliver Stringfield, our Speaker, our Secretary, and others. They had a few disciples with them. I was one of the disciples.

It was a frustrating experience to see the confusion and to see the apathy in some of the high places in American medicine regarding this problem. It was frustrating to see committees, not only in Connecticut, but throughout the country, spending hours and hours working on this plan. Practically all their time was spent on a fee schedule, as if a fee schedule was the only important thing in the plan, and as if it was static and couldn't be changed.

Finally, too much time was frittered away that American medicine had to put on a vast propaganda campaign—and it was a propaganda campaign. It had no solution. Its purpose was to scare the pants off the politicians so as to give us time so the Blue Shield Plan, and plans such as Connecticut Medical Service, could get started in this country—and it did accomplish its purpose.

Those of us who have been exposed to this problem again see a little apathy in some high places in American medicine. We see some shortsightedness on the part of some groups in medicine regarding this problem of third-

party payments. That is the reason for my message to you today: because I am confident that groups, such as you are, having the facts will act accordingly; and those of us who have given a lot of time to this problem and know the facts will not again be frustrated as we were fifteen years ago, and see American medicine turn over the third-party problem to nonphysicians when they can do it better themselves—not only for themselves, but also for their patients.

Thomas J. Danaher

REPORT OF THE COMMITTEE ON
POSTGRADUATE EDUCATION

Hugh L. Dwyer, *Chairman*

Arthur Ebbert	Marvin Lillian
Richard B. Elgosin	Robert M. Lowman
Malcolm M. Ellison	Benjamin E. Lyons
William J. Lahey	A. Rocke Robertson

In the past year the Committee has planned and executed the 1954 Clinical Congress. The Congress was again confined to two days with as many as three meetings taking place concurrently. This followed the pattern established in the last two years. There were 423 paid registrants and 645 registrants total.

The Committee has spent some time deliberating about the cause for the continuing reduction in the registration at the annual Clinical Congress. A summary of the registration from 1948 to 1954 might be in order for comparison.

YEAR	PAID REGISTRATION	TOTAL REGISTRATION
1948	603	793
1949	515	677
1950	432	530
1951	398	531
1952	598	819
1953	481	736
1954	423	645

As a result of the deliberations of the Committee a questionnaire was prepared and mailed to each member of this Society in the fall of 1954. This questionnaire included information pertaining to the need for the Clinical Congress, as well as for certain postgraduate courses that had been under consideration. The results of this questionnaire have been summarized and copies of the summary have been distributed to the House of Delegates for this meeting. The response in terms of the number of questionnaires returned was excellent. The general reaction, however, to the answers of the majority of questionnaires returned is that there is a general apathy toward the continued existence of the Clinical Congress, as well as to postgraduate courses in almost any form. A good many people who returned the questionnaires wrote thoughtful comments, most of which expressed some appreciation to the Committee for its efforts and pointed out the increasing number of local meetings and the hospital programs which have in the past few years perhaps supplanted the Clinical Congress. On the other hand, it should be noted that the registration for this Congress included a not inconsiderable group of people who apparently feel the need for this meeting and enjoy attending. The 1948 registration of 603

was the highest attendance in the history of the Clinical Congress. The figure for the last year does not differ a great deal from the peak years of 1948 and 1952.

Shortly before the writing of this report the whole Committee met for a full consideration of the problem. The Committee found it impossible to reach a majority conclusion as to what its recommendation be in terms of the continued existence of the Clinical Congress. Half of the membership of the Committee felt that it should be continued along the same general lines as it has been in the recent past, despite the fact that the available post-graduate instruction, of this form, has increased tremendously throughout the State. Having been unable to reach a decision on this point, the Committee felt that the facts should be presented to the House of Delegates at this time in the hope that the House itself might decide the question.

Respectfully submitted,
Hugh L. Dwyer

QUESTIONNAIRE SURVEY OF 1954 CLINICAL CONGRESS

Questionnaires Sent Out 3,008 — Returned 1,081

- 1. Did you attend the 1954 Clinical Congress?
312 Yes; 769 No.
- 3. Have you ever attended the Clinical Congress?
Of those who did not attend—625 Yes; 144 No.
- 4. Do you think more physicians would attend if the \$3 Registration Fee was discontinued and expenses met from general funds of the Society?
Of those who did attend—62 Yes; 239 No.
Of those who did not attend—135 Yes; 600 No.
- 5. Would you be more likely to attend if the sessions were held only in the afternoons of three or four days and no morning sessions?
Of those who did attend—91 Yes; 211 No.
Of those who did not attend—311 Yes; 418 No.
- 6. Do you favor any of the following suggestions for the program:
 - a. More panel discussions.
Of those who did attend—180 Yes; 29 No; 101 No comment.
Of those who did not attend—342 Yes; 40 No; 359 No comment.
 - b. More question and answer time.
Of those who did attend—103 Yes; 48 No; 158 No comment.
Of those who did not attend—170 Yes; 96 No; 506 No comment.
 - c. Clinico-pathological conferences.
Of those who did attend—85 Yes; 51 No; 172 No comment.
Of those who did not attend—186 Yes; 84 No; 502 No comment.
 - d. Non-clinical subjects such as medical economic and social questions.
Of those who did attend—83 Yes; 78 No; 149 No comment.
Of those who did not attend—178 Yes; 136 No; 456 No comment.

- e. A social hour and dinner meeting.
Of those who did attend—57 Yes; 76 No; 177 No comment.
- Of those who did not attend—168 Yes; 132 No; 467 No comment.
- If you are interested in other types of post graduate programs which do you favor?
 - Ia. Programs at some center such as Hartford or Bridgeport?
343 Yes; 69 No; 669 No comment.
 - b. Programs at your local hospital or county medical association.
336 Yes; 45 No; 700 No comment.
 - IIa. Concentrated—several full days at a time.
99 Yes; 56 No; 926 No comment.
 - b. Concentrated—one full day.
279 Yes; 33 No; 769 No comment.
 - c. Intermittent—one afternoon or evening a week for several weeks.
311 Yes; 49 No; 721 No comment.
- IV. Are you in General Practice?
Of those who did attend—83 Yes; 229 No.
Of those who did not attend—228 Yes; 541 No.

REPORT OF THE MEDICAL ADVISORY COMMITTEE TO THE JOINT COMMISSIONS

Chester W. Fairlie, Jr., Chairman

John C. Allen	Harold Ribner
Frieda G. Gray	Sidney Shindell
Ronald H. Kettle	Harold E. Speight

The Committee on Chronic Illness received no communications for its consideration during the year 1954-1955 and did not meet in formal session. The Chairman responded to one request to appear before the Council of the State Medical Society for discussion of a proposal concerning the care of chronically ill in this state.

Commencing on July 1, 1955, it has been planned that the Committee on Chronic Illness of the Connecticut State Medical Society will serve as the Medical Advisory Committee to the Joint Commission (Veterans Home and Hospital Commission and the Commission on Chronic Illness). The Chairman of the present Committee on Chronic Illness attended the final meeting of the previous Medical Advisory Committee in order to facilitate this transition.

On January 24, 1955, Dr. Sidney Shindell, of this committee, submitted a letter to the Society suggesting that he and Dr. Frieda Gray should be relieved from their position on the Committee on Chronic Illness, since with the Committee's new role as Medical Advisory Committee, he and Dr. Gray would be in the anomalous role of being advisors to their own organization.

It is anticipated that its role as Medical Advisory Committee will enable the Committee on Chronic Illness to be more active and effective during ensuing years than during the past one.

Respectfully submitted,
Chester W. Fairlie, Jr.

REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH

Preston N. Barton, *Chairman*

Harold A. Bergendahl	J. Wister Meigs
Norton Canfield	Philip J. Moorad
Roland Z. Carignan	Frank T. Oberg
George H. Carter	John D. O'Connell
Bernard S. Dignam	Israel S. Otis
John N. Gallivan	Norman Righthand
Richard J. Hinchey	Philip E. Schwartz
Andrew J. Jackson	Harold P. Stetson
J. Howard Johnston	Paul W. Vestal
John F. Kilgus	Elwood C. Weise
Thomas F. V. LaPorte	Harold W. Wellington
William Lee	J. Alfred Wilson
Daniel F. Levy	C. Frederick Yeager

This year the activities of the Committee on Industrial Health were organized primarily on a sub-committee basis. Sub-committees were formed on Liaison with County Industrial Health Committees, Program and Education, Workmen's Compensation and Rural Occupational Health.

The major effort regarding the augmentation of the activities of the County Committees on Industrial Health was the holding of bipartite meetings of the Executive Board of this Committee and the County Committees. This effort was well worth while. The opportunity was afforded to give greater background to the County Committees and to indicate to them areas of future constructive interest and activity.

A basic problem in the field of industrial health has always been the education of physicians. They have been given so little background in the various aspects of industrial and occupational medicine in the course of their professional training. This year through the cooperation with this Committee, the Section on Occupational Health, Department of Public Health, Yale School of Medicine and the Bridgeport Chapter of the American Academy of General Practice, a 16 hour course in Occupational Medicine for General Practitioners has been offered and is being well received. This follows the pattern that has been recommended on a national basis, and is in line with a similar program given in Litchfield County in 1953.

A program to make available a spectrum of industrial medical subjects to hospital staff program committees for use in their regular hospital educational programs is in its formative stages. It is hoped that this will be activated in the near future.

The Sub-Committee on Workmen's Compensation has studied the brochure published by the American Medical Association, Council on Industrial Health entitled "Medical Relations in Workmen's Compensation in Illinois" to determine whether a similar study should be carried out in Connecticut. The consensus of the Committee was that the Connecticut Workmen's Compensation Act is for the most part a good one, well administered, and is so considered both in this State and elsewhere. It did not seem expedient to tamper with it at this time. This group is particularly active at the present time, studying the proposed changes in the present legislature and making recommendations to the Society for action.

The Sub-Committee on Rural Occupational Health was formed in recognition of the increasing toxic hazards to agricultural workers inherent in the many new pesticides that have come into widespread use in recent years. There are over 50,000 different brands of various pesticides individually or in mixtures. Many of these are highly toxic to man and toxic quantities may be inhaled, ingested or absorbed through the skin. While the activities of this group are still in the formative stage there are plans underway to place concise therapeutic information in all hospital emergency rooms in the state, and work with agricultural groups in an effort to disseminate useful information to the public. Through this Society and the State Board of Health it is hoped that individual physicians may obtain a better understanding of the problems that exist including, the preventive measures required, recognition of cases and recommended modes of therapy. To our knowledge this is the first effort of this nature by a State Medical Society Committee, but information is now appearing in the *Journal* of the American Medical Association from the Council on Pharmacy and Chemistry prepared by their Committee on Pesticides.

The activities of this Committee during the year have been a springboard for future action. With the formation and beginning activation of the County Committees on Industrial Health, many matters will be handled at a more local level in the future. The new trends outlined here for the State Committee on Industrial Health should result in a continuing leadership in industrial health advancement that has been so evident and recognized in the past.

Respectfully submitted,
Preston N. Barton

REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND LICENSURE CONNECTICUT MEDICAL EXAMINING BOARD FOR THE CALENDAR YEAR 1954

John D. Booth, President

John H. Bumstead	Louis P. Hastings
C. Louis Fincke	Carl E. Johnson
Creighton Barker, Secretary to the Board	

The Connecticut Medical Examining Board is the Society's Committee on Medical Education and Licensure and this report of the Committee is the official report of the Medical Examining Board.

The membership of the Board continues as before. Governor Lodge reappointed John D. Booth, for the term of five years commencing January 1, 1955.

The Board held six regular meeting during 1954 as required by the Medical Practice Act and five special meetings. Charges brought by the State Department of Health against three physicians were heard by the Board, two for conviction of federal income tax evasion and one for drug addiction. One license was revoked.

Three hundred and nineteen persons were certified as eligible for licensure. The methods of obtaining such certifications were as follows: one hundred and seventy-nine

presented certificates issued by the National Board of Medical Examiners; one hundred and two presented acceptable licenses issued by twenty-four states and thirty-eight were certified on the basis of written examination. Fifty-nine individuals took the licensing examinations seventy-three times. Thirty-eight of these candidates were successful and thirty-five of the seventy-three examinations were failed. This is the largest number of candidates the Board has processed in any one year.

The states from which credentials were presented were: New York 36; Maryland 8; Ohio 7; Kansas 4; Louisiana 4; Michigan 4; Tennessee 4; California 3; Indiana 3; Massachusetts 3; Missouri 3; Vermont 3; Illinois 2; Minnesota 2; Nebraska 2; New Jersey 2; North Carolina 2; Pennsylvania 2; South Carolina 2; Virginia 2; Kentucky 1; New Hampshire 1; Rhode Island 1; South Dakota 1.

Four of the failures were graduates of four American or Canadian schools. Twenty-nine of the fifty-nine candidates, graduates of twenty-three medical schools located outside of the United States and Canada, took the examinations seventy-two times. Of these twenty-nine candidates, twelve finally passed, a failure rate of 59%. The schools represented and the number of candidates from each were: University of Berne, Switzerland 1; University of Budapest, Hungary 3; University of Brussels, Belgium 1; University of Catania, Italy 2; Charles University, Prague, Czechoslovakia 2; University of Freiburg, Germany 2; University of Gottingen, Germany 2; University of Graz, Austria 3; University of Havana, Cuba 2; University of Naples, Italy 5; National University of Ireland, Galway, Ireland 1; University of Rome, Italy 3; University of Vienna, Austria 4.

The schools that provided the greater number of graduates during 1954 were:

State University of	Jefferson Medical College	6
New York	McGill University	6
New York University.....	University of Rome	6
Yale University	University of Vienna	6
N. Y. Medical College.....	University of Buffalo	5
Columbia University	Georgetown University	5
Tufts College	University of Graz	5
Harvard University	University of Naples	5
University of Rochester 10	Temple University	5
Cornell University	University of Tennessee....	5
Boston University	University of Geneva.....	4
Johns Hopkins University 6	University of Tulane.....	4
University of Budapest.....		6

Sixty-one other schools were presented by three or less.

Connecticut law allows a registered osteopath to appear before the Medical Examining Board and take the examinations in medicine and/or surgery; and if successful in either or both, he is given a full license to practice medicine and/or surgery in addition to osteopathy. Three osteopaths availed themselves of this privilege. Three took the examinations in Medicine and two were successful. One took the examination in Surgery and was successful.

The Educational Permit provision, included in the amendments to the Medical Practice Act by the Connecticut General Assembly of 1953, continues to operate in a most satisfactory manner. Eighty-nine Permits were issued in 1954 and the effect of this was to add that number of

physicians to the intern and resident staffs of Connecticut hospitals who otherwise could not have been employed.

Respectfully submitted,

John D. Booth

REPORT OF THE COMMITTEE ON PUBLIC HEALTH

Robert R. Keeney, Jr., Chairman

Clement F. Batelli	Clifford Joseph
David H. Bares	Luther K. Musselman
John W. Buckley	Robert P. Rogers
Alfred L. Burgdorf	J. Harold Root
Francis H. Burke	Edward T. Wakeman
Clarence W. Harwood	William A. Wilson
Louis P. Hastings	Joseph M. Wool

F. Lee Micklc, Associate Member

The Committee on Public Health has met every month and discussed many problems. The attendance has been very good and considerable time devoted to our work. All decisions have been forwarded to the Council for final approval.

The Committee is still in doubt about its position with the State Board of Health in relation to its programs in prevention and detection of chronic disease and illness. The Programs for Chronic Disease and Control for the years 1949 to 1954 were approved by the Council and later given partial disapproval by the Council.

The Committee considered the problem of Recognition and Care of Children Who Have Retroental Fibroplasia and a letter to all physicians in Connecticut will be sent by the State Board of Health outlining the latest medical facts in diagnosis and therapy.

The Committee recommended to the Council the creation of a Permanent Committee of Child Health to work with the State Boards of Health and Education and other agencies concerned with children and this has been done.

The Committee considered the problem of the 1955 Field Trials for Poliomyelitis vaccination and has given tentative approval providing the Council will approve this action. The 1954 vaccinations for polio went off with no troubles or complications. Dr. Thomas Francis of the University of Michigan will give a report on the 1954 field trials in April 1955 before the present trials are started. The National Foundation will again furnish all material for the vaccinations which will be given by voluntary workers and physicians.

The Committee is considering the Subject of Medical Guidance for Voluntary Agencies and will forward material to the Council in the future on this subject. We believe the medical profession should take a more active interest in the activities of these numerous voluntary health agencies.

The Committee on Public Health has had a very active year and considered many problems pertinent to the practice of medicine. It will continue to show interest in any field of medicine and health that affects the health of the citizens of Connecticut.

Respectfully submitted,

Robert R. Keeney, Jr.

REPORT OF THE COMMITTEE ON PROFESSIONAL RELATIONS

William H. Upson, Chairman

Harold W. Higgins

Charles S. Knapp

Seymour I. Kummer

Israel S. Otis

Frank L. Polito

William J. Tate

The Committee on Professional Relations has had but one case to investigate; this case coming from Hartford County Medical Association.

This necessitated two meetings of the Committee, the first of which was held on Wednesday, February 9, 1955, and the second on Wednesday, February 23, 1955 at the Connecticut State Medical Society building. Reports and findings on these meetings were forwarded to the individuals involved, to the Committee on Medical Ethics and Department of the Hartford County Medical Association, and to the Executive Secretary of the State Medical Society.

The Committee wishes to re-emphasize the necessity for disinterested physicians to refrain from expressing opinions in cases in which they are not directly involved. It was found that a great deal of misunderstanding in the above case arose from such actions.

Respectfully submitted,
William H. Upson

REPORT OF CRIPPLED CHILDREN TECHNICAL MEDICAL ADVISORY COMMITTEE

Edward T. Wakeman, Chairman

Norton Canfield

Burr H. Curtis

David Gaberman

Denis S. O'Connor

Edward J. Ottenheimer

Robert P. Rogers

William M. Shepard

C. Norton Warner, Jr.

Herman Yannet

This is a subcommittee of the Committee on Public Health of the Connecticut State Medical Society.

One meeting was held June 7, 1954.

1. Dr. Carl Gade and Dr. Arthur Griswold had tendered their resignations as orthopedic consultants to the Division of Crippled Children. Both had been consultants since 1938, the former to the Stamford Crippled Children Clinic and the latter to the Danbury Crippled Children Clinic. The committee expressed appreciation for these many years of faithful service.

The committee recommended that Dr. Becket Howorth be appointed to fill the vacancy in the Stamford Clinic beginning July 2, 1954 and that Dr. Richmond Stephens be appointed to fill the vacancy in the Danbury Clinic beginning August 26, 1954.

2. The committee recommended that the present consultants to the Division of Crippled Children be reappointed.

3. Nephrosis program. The question as to budgeting of funds for hospitalization and prophylactic drugs for nephrosis were discussed in detail. It was reported that ten

children had received hospital care under the program. Dr. Robert E. Cooke, Associate Professor of Pediatrics and Physiology at the Yale School of Medicine gave one or more talks on nephrosis to each of the following hospitals: Danbury Hospital; St. Francis Hospital; Stamford Hospital; Hartford Hospital; Lawrence and Memorial Hospital; St. Raphael's Hospital.

The cost of hospital care and appropriate drugs is a major problem in handling children with nephrosis. The committee recommended that the Division of Crippled Children use the limited available funds for hospital care as needed by individual patients. It was the general feeling of the committee that cortisone and antibiotics for nephrosis can be considered preventive measures and that they do shorten hospitalization and make relapses less frequent. Hence funds could be used for the purchase of drugs at the discretion of the director if these funds are not more urgently required for hospitalization.

4. Hearing Conservation Program. Several certified otologists have requested aid for their patients in the purchase of hearing aids as an isolated service, without referral to the State Hearing Conservation Clinic in Hartford or the Audiology Clinic at the New Haven Dispensary. (The latter is presently providing services to the children in southern Connecticut, referred by the Division of Crippled Children.)

The need for comprehensive service for children with hearing loss is well established and the Division of Crippled Children should do everything it can to make this fact known and understood. If adequate records are available and adequate assistance in the use of the aid by qualified speech and hearing teachers is arranged, the aids can be provided to patients needing them.

5. Cleft Palate Program. The need to integrate the various services required in the care of the child with cleft palate is well recognized. A trial clinic, attended by a pediatrician, surgeon, dentist, orthodontist, speech therapist and otologist was held May 27, 1954 to discuss several cases under care of the Division of Crippled Children. The cooperation and coordination of various disciplines offers the best chance for successful habilitation of cleft palate cases.

This committee and the Division of Crippled Children was well represented in a group of physicians and dentists who visited the Cooper Clinic in Lancaster, Pennsylvania, July 8 and 9, 1954. Dr. Cooper has clearly demonstrated the value of a team approach to the problems of rehabilitation.

6. Changing character of the regular crippled children program.

Orthopedic surgeons are now settling in smaller cities and orthopedic clinics are starting in some of the local hospitals. It is expected that these developments will have their effect upon the state clinics. The special services which the state clinics are able to provide for the more difficult orthopedic cases may not become available locally but many of the simpler services will probably become more and more available.

The orthopedic needs appear to be decreasing and the non-orthopedic to be increasing. It has been suggested that

the clinics and the crippled children program itself should be adapted to care for the non-orthopedic crippled children. It has been suggested that they might prove more useful to people of Connecticut if they embrace a variety of handicapping non-orthopedic conditions.

The technical medical advisory committee has added from time to time to the original definition of a crippled child other important handicapping conditions as those conditions which were more numerous and conspicuous were being taken care of and as the committee saw the need for other services.

The addition of services for children with rheumatic fever, cardiac disease, cleft palate, hearing loss, epilepsy and nephrosis to the crippled children program testify to the change and emphasis.

It was the opinion of the committee that the name "crippled children clinic" should be retained and that the change in emphasis from orthopedic to non-orthopedic services will probably continue, but any fundamental change in function would be inadvisable. The recommendation of the Connecticut Branch of the Academy of Pediatrics for the establishment of pediatric clinics in eastern Connecticut was recalled also but no funds for this purpose were allocated by the legislature.

However, the thought was expressed that it is a function of the Division of Crippled Children to encourage the development of local resources and this function should receive emphasis. In many fields of medical endeavors there are demands for centralized institutional care of patients with chronic disease. This demand might well lead to ill considered hospital construction at great expense. Development of clinic and home care services locally for the chronically disabled should counteract this trend. The division of Crippled Children certainly has a part to play in developing such services for children with chronic conditions.

Respectfully submitted,
Edward T. Wakeman

REPORT OF THE COMMITTEE ON SCHOOL HEALTH

Joseph L. Hetzel, Chairman

Ira Beebe, D.D.S.	Charles Murphy
Miss Ruth Byler	Stanley H. Osborn
Martha Clifford	Leonard Parente
Mr. Finis Engleman	James H. Root, Jr.
Henry Louderbough	J. Harold Root
Charles Wilson	

Your committee has been active, meeting each month except July and August with two meetings in February. Attendance has been good.

Dr. Murphy resigned as chairman at the March meeting and has been succeeded by Dr. Hetzel.

The formation of the "State Advisory Council on School Health" particularly desired by this committee has been completed. The Council brings the State Department of Health and of Education together with representatives of this Society, the Dental Society and various pertinent health and education agencies. It is working vigorously and effectively under the guidance of Dr. William Nolan, Rural Superintendent of Schools. This Council will have strong impact on School Health and the formation of School Health Councils in this State.

An improved immunization record form has been devised by this committee, approved by the Advisory Council and the Departments. When printed this form will replace one currently in use. Physicians will be asked to cooperate in its use.

The October meeting was addressed by Dr. Parker Dooley of South Kent. This was a stimulating session. Many of the methods and ideas advanced by Dr. Dooley were greatly to be desired for all public schools but not attainable at this time. However, his impression of the importance of a child's first contact with school resulted in this committee referring the matter to the Advisory Council. A sub-committee was thereby appointed to review the subject, revise current literature, and provide effective distribution therefor.

Discussion of the "Summary Report on the Status of Health Education in Connecticut for 1954" reveals a great need for designation of responsibility for school health to a single interested able person, to get the work centralized, and off the docket of the over worked superintendent or principal; as well as for a workable curriculum guide and for School Health Councils. This subject is being pursued.

Out of this discussion grew two projects. The first was to learn what our State Teachers Colleges are teaching teachers in the field of Health. This led to a meeting of this Committee with representatives from each college in March.

The second project currently occupies the Committee fully. This will take the form of a "State Conference for Physicians and Schools" to be held in the Fall with the approval of the Council. This will provide a means of delineating responsibility, clarifying needs, and establishing mutual understanding between educators, school physicians, private physicians and health officers. Dr. Fred Hein of the A.M.A. has given this Committee and Dr. Barker the benefit of his experience with similar conferences in 30 other States. This conference should mark a significant forward step in better school health for Connecticut.

Respectfully submitted,
Joseph L. Hetzel

REPORT OF THE COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Chairman

Harold A. Bergendahl

Morris A. Hankin

Burdette J. Buck

Harry C. Knight

James C. Caniff

James H. Root, Jr.

Co-ordination of public relations activities between national, state and local associations has developed markedly during the past year.

This has been particularly evident in the rapid growth of medical television; publication of a standard AMA public relations manual for county use; association's increased use of films, exhibits, and radio transcriptions in education programs; and the expansion of community service activities.

A considerable amount of time has been devoted to television activities in Connecticut. This has been directed toward audience promotion for national network productions such as *The March of Medicine*, *Medic*, and *Horizons*. Actual production was undertaken last September when four weekly, 15-minute telecasts on health topics were presented over the facilities of WNHC-TV, New Haven. This was in cooperation with the Connecticut TV Committee for Health Education, an organization of 15 leading state-wide health agencies.

The AMA Public Relations Manual, an outstanding reference and guide for local activity, is currently being distributed to county officers and members of county Public Relations Committees. The manual is intended for distribution only to association officers and Committee members who are actively engaged in public relations planning. Content of the publication is soundly based on the experience of a large number of associations in operating projects ranging from emergency call plans to press-radio and TV relations, Mediation Committees, Speakers' Bureaus, membership indoctrination, public service projects and citizenship activities.

The increased use of films, exhibits and radio transcriptions is another example of a co-ordinated planning. These materials are provided by the AMA and can be readily used in programs by local associations. These services are being used in our state and ways are presently being sought to utilize them more fully.

Perhaps the best example of co-ordinated planning during the year was the first nation-wide observance of Community Health Week, March 21-27 by the US Junior Chamber of Commerce. This was conducted in cooperation with the National Health Council, AMA, and state and local associations. Plans for the observance in Connecticut were made with state officers of the association and officers of county and local associations were requested to cooperate in planning local activities.

In addition to the community service and other activities in which the committee is engaged, there is an extensive area of cooperation with other communities. From time to time, certain committees call upon the Public Relations services to assist in advancing certain projects. The considerable number of committees of the Society which are engaged

in activities closely associated with the public interest make this area of activity of special value.

Several new activities were initiated during the year. One of these comprises a Course in Economics of Medical Practice for fourth year medical students at the Yale School of Medicine. This course was inaugurated early in January following approval of the recommendation by the Council. The Course was arranged by Dr. Ira V. Hiscock, Head of the Yale Department of Public Health and Dr. Creighton Barker, Executive Secretary of this Society. It comprised nine weekly sessions on the problems of entering practice, physician-patient relationships, types of medical practice, the economics of maintaining a practice, legal problems and relationships with voluntary and government agencies. Plans are being made to continue the course next year.

Another new project was the publication of a first-aid chart in cooperation with the Woman's Auxiliary for distribution at fairs and organization meetings. The chart has proved highly popular and plans are being made to expand distribution by organizations desiring to obtain the charts at production cost.

A health record for family use has been developed and plans are now being considered concerning the most useful type of distribution for this service type of publication.

A series of new radio programs on health education was also initiated. This project was also undertaken with the cooperation of the Auxiliary and comprises the use of transcriptions furnished by the AMA. These programs of 13 week duration are now being used by community radio stations in Torrington, Stamford, and Middletown. It is anticipated that the programs will be conducted throughout the year and that additional stations will cooperate in using them.

Principal projects started several years ago and which are being continued may be briefly noted as follows:

Newspaper Health Column—This weekly column, titled "Your Health," is written for Connecticut's 55 weekly newspapers throughout the year.

Country Fair Exhibits—Sponsored by the Society's Committee on Rural Health in cooperation with the Woman's Auxiliary and Connecticut Medical Service, these exhibits were displayed at a larger number of fairs than ever before. Six portable exhibits were designed for this project and they were used at 16 fairs.

In addition to these fairs, service was extended to the Fairfield County Medical Association for the display of an anatomical exhibit at the ten-day Danbury Fair. This proved to be so popular that plans are being made to continue it next year.

Community Service Exhibit—This exhibit was specially constructed last year to depict the growth of emergency call plans. It has been used for display in hospital lobbies in Hartford County and is currently being used for the same purpose in Fairfield County.

Press, Radio and TV News—Information concerning the activities of the Society and component and allied associations was furnished to news, radio and television media, during the year. A number of special articles were written for news letters and professional journals.

"*Today's Health*"—The Committee has cooperated with the Woman's Auxiliary in increasing subscriptions to this popular health magazine published by the American Medical Association. Information concerning the publication was prepared for several issues of the *Connecticut State Medical Journal* and several exhibits were prepared for medical meetings.

Connecticut State Medical Journal—A section on public relations activities and a page for AMEF and other projects were written for each issue of the *Journal*. A number of special articles were also prepared.

The Committee sincerely appreciates the cooperation of members of this Society in appearing on television programs, speaking before community groups and in other ways contributing to public relations activities.

Respectfully submitted,
William G. H. Dobbs

REPORT OF THE CONNECTICUT COMMITTEE FOR THE AMERICAN MEDICAL EDUCATION FOUNDATION

William G. H. Dobbs, Chairman

G. Robert Downie	Charles E. Jacobson
Harry S. Frank	Milton M. Lieberthal
Paul J. Garity	Mervyn H. Little
Orvan W. Hess	Marjorie A. Purnell

The present Committee was appointed by the Council last October. The action followed a request by the Public Relations Committee that it be relieved of AMEF planning in order to devote more time to community service programs and other aspects of the Public Relations program.

Our Committee has held two meetings and is now engaged in conducting the 1955 AMEF Campaign. The campaign will generally comprise mailings to physicians from the offices of the State Medical Society, with follow-up mailings from county associations when practicable.

In addition to planning for the state campaign, our Committee was invited to participate in a national AMEF Conference held in Chicago on January 23. This Conference was attended by the Chairman of the Committee and Mr. James G. Burch, member of the Society's staff in charge of the administration of Connecticut AMEF activities, as guest speakers. The Connecticut portion of the program comprised a presentation of the plans and operation of the 1953 campaign of personal solicitation.

The 1954 campaign brought total contributions from Connecticut physicians of \$12,862.00. The number of contributors, 381, represents 12.6% of the approximately 3,000 members of the State Medical Society. The figures indicate an appreciable increase over the previous year, when 244 physicians contributed \$8,488.00.

This year a state-by-state tabulation of contributions to medical school alumni funds has been made available for the first time. It is gratifying to find that 1,026 Connecticut physicians have contributed to these funds, with total contributions of \$26,458.00.

Added to the contributions that went to medical schools

through AMEF, these figures bring the grand total to \$39,348.00 from 1,407 contributors.

These totals assure that Connecticut will retain its position among the leading states for the 1954 campaign. The comparison indicates that Connecticut ranked ninth in the number of contributors and eleventh in the amount of physicians contributions. Although this record shows marked improvement, the percentage of contributors still is lower than it should be if physicians in Connecticut and other states are to carry a full share of responsibility for assisting the medical schools.

It is of particular interest to this Committee that so many physicians are contributing directly to their schools through alumni funds. It is also encouraging to note that in a number of instances physicians are contributing to both alumni funds and to AMEF. It is highly noteworthy, too, that a number of physicians contributed to the 1954 AMEF campaign two or more times.

The total national contribution by physicians to AMEF in 1954 amounted to \$681,928.00 from 22,996 contributors. In addition, \$500,000 was contributed to AMEF by the American Medical Association. Alumni contributors numbered 57,578 physicians and the total amount raised was \$1,824,269.00. Adding these figures produces a total of \$3,006,197.00 from 57,578 physicians, the AMA and other associations.

The Woman's Auxiliary played a highly active part in the 1954 campaign and raised a total national contribution of more than \$50,000.00. Every chapter of the Woman's Auxiliary to the Connecticut State Medical Society contributed, the total amount exceeding \$1100. These contributions represented proceeds from such fund-raising activities as rummage sales, teas, bridge parties and dances.

It is a matter of concern that many physicians believe that if they are contributing to alumni funds it is not necessary to consider AMEF. This notion was given some substance during the first two campaigns, when allocations to the medical schools from AMEF general funds were distributed according to the degree of success of alumni funds. This arrangement was later changed and now funds are allocated to the schools without reference to alumni activities.

Aside from the amounts raised by the alumni funds, the schools need an additional \$10,000,000 annually. AMEF is obligated to raise \$2,000,000 of this amount and the remaining \$8,000,000 is to be raised annually by the National Fund for Medical Education, which is organized to accept contributions from business corporations. It is therefore important that every physician help AMEF to fulfill its obligation—and it should be constantly stressed that AMEF contributions may be earmarked for any approved medical school in the United States without deduction for administration expenses since these are paid by the American Medical Association.

Our Committee is deeply appreciative of the generous response of an increasing number of Connecticut physicians during each campaign and urges every physician to participate in the campaign for 1955.

Respectfully submitted,
William G. H. Dobbs

(To be continued)

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Newell W. Giles, Darien

President-Elect, Mrs. Norman J. Barker, Collinsville

First Vice-President, Mrs. J. ALFRED WILSON, Meriden

Second Vice-President, Mrs. Frank L. Polito, Torrington

Recording Secretary, Mrs. Charles Culotta, Hamden

Corresponding Secretary, Mrs. C. Murray Gratz, Cos Cob

Treasurer, Mrs. Joseph Woodward, New London



MRS. NORMAN J. BARKER

Mrs. Norman J. Barker was installed as president of the Woman's Auxiliary at the annual meeting held on April 27 at the Brooklawn Country Club. The following slate of officers was elected: President-elect, Mrs. E. Roland Hill; 1st Vice President, Mrs. Charles Murray Gratz; 2nd Vice President, Mrs. Morton Arnold; Corresponding Secretary, Mrs. James Stretch; Recording Secretary, Mrs. Charles S. Culotta; Treasurer, Mrs. Joseph Cutler Woodward.

County presidents elected for the coming year are: Fairfield, Mrs. Charles Sheard; Hartford, Mrs. Charles Sullivan; Litchfield, Mrs. Winfield Wight; Middlesex, Mrs. Louis Soreff; New Haven, Mrs. David McGaughey; New London, Mrs. Hugh Lena, Jr.; Windham, Mrs. Winston Hainsworth.

American Medical Education Foundation

In her annual report, Mrs. Edward Wakeman, chairman of AMEF, reported receipt of \$1,136.62 and the expectation of total contributions in the amount of \$1,200 for the year. At the annual meeting Mr. John Hedbach, assistant executive director of

AMEF, addressed the group on the "Role of the Auxiliary in the AMEF." Fairfield, Hartford, New Haven, New London and Windham counties provided for the Foundation in their budgets. Hartford supplemented this figure by a bridge, New Haven by a silver tea, and New London by a luncheon and dinner-dance. Middlesex county's contribution was raised by individual member projects.

Finance

Due to a change in the fiscal year it was necessary for the Finance Committee, Mrs. William V. Wener, chairman, to draw up two proposed budgets this year. The first was for a four month period—January 1 to April 30, 1955, the second for May 1, 1955 to April 30, 1956. A new form of voucher was instituted similar to that used in other State auxiliaries and National, making it possible to itemize bills more thoroughly. This will facilitate matters for the treasurer and give a more precise picture of our finances.

Medical and Surgical Relief

This committee under the chairmanship of Mrs. Irving H. Krall, attempted to undertake two projects this year. The first was the collecting of medical samples from doctors' offices and sending them to the Medical and Surgical Relief Committee, Inc., of New York. The second was the collecting of medical journals and publications to be sent to the Darien Book-Aid which distributes them to countries where such materials are needed. Hartford County, under the chairmanship of Mrs. Sidney Burness, shipped a two and one-half ton truck filled with medical samples to the New York office, and sent a large collection of books and journals to the Darien Book-Aid Plan. Litchfield, under the chairmanship of Mrs. James T. Smith, collected and sent medical samples to New York. Windham, under the chairmanship of Mrs. James T. Anderson, collected and sent both medical literature and medical samples.

OBITUARIES

William H. VanStrander, M.D.

1876 - 1955



William Harold VanStrander died at St. Francis Hospital in Hartford on January 12, 1955, at the age of seventy-nine, after a brief illness.

Dr. VanStrander, a native of Edenville, New York, received his M.D. degree from the University of Vermont College of Medicine and after serving an internship at the Hartford Hospital, located in Hartford as a general practitioner in 1902.

Dr. VanStrander soon became interested in the field of x-ray which was then in the pioneer stage. Ultimately he devoted most of his time to roentgenology and became head of the Department of Roentgenology at St. Francis Hospital where he served most capably until 1946.

His was a full life. Notwithstanding the demands made upon him in his specialty he always found time to continue his care of the patients who had sought his aid when he was in general practice and who continued to depend upon him for advice and counsel.

Dr. VanStrander was a successful physician and retired from practice only a few months before his death. He was a member of the American Roentgen

Society, the American Medical Association, the Hartford Medical Society and the Hartford County Medical Association.

Outside of his practice Dr. VanStrander was a family man first of all, kindly and devoted. He had a small circle of close friends with whom he sought simple recreation. He had two hobbies, horticulture and landscaping from which he derived much pleasure.

Dr. VanStrander was a veteran of World War I, a member of St. John's Episcopal Church in West Hartford and St. John's Lodge, A. F. & A. M. Surviving are his wife, Helen E. Savage VanStrander, two sons, William and Phillip and one daughter Mrs. Pierce R. McConaughy.

Arthur B. Landry, M.D.

Arthur D. Marsh, M.D.

1886 - 1953



Dr. Arthur Marsh of Hampton died on March 13, 1953 in Bradenton, Florida at the age of 67, after a prolonged cardiac illness. He was born on October 7, 1886 in Oriskany Falls, New York, but received all his early education in New Haven where his father, Dr. Arthur Washburn Marsh, carried on a large general practice until his death in 1925.

Arthur Marsh received his medical education at the Yale University School of Medicine, from which he was graduated in 1908. He then interned at St. Luke's Hospital in Utica, New York, and in 1912 began general practice in Hampton, Connecticut. This was interrupted by World War I, during which he was commissioned a First Lieutenant and stationed at Camp Custer, Michigan.

After the war Dr. Marsh returned to Hampton, and in 1922 was married to Hazel VanTine of Bradford, Pennsylvania, who survives him. He is survived also by one daughter, Mrs. H. Wales Clark of Old Saybrook, Connecticut, and her two children.

Dr. Marsh for many years was the only physician in the small town of Hampton. As a result, he was not only the complete family doctor in the true sense of the word, but also became prominently identified with the educational, cultural, and civic activities of his community. He was highly respected for his sound judgment and professional skill. Up until the time that it became necessary to retire from practice because of his health, he was a member of the courtesy staff of the Windham Community Memorial Hospital, where he was held in the highest esteem by his colleagues.

Edward J. Ottenheimer, M.D.

Single Rod and Snake — Not Double

The extent of our current familiarity with the classics, for example, may be guessed from the widespread and unquestioned acceptance of the caduceus of Mercury as the symbol of the medical profession. Our correct aegis is the single rod and snake of Aesculapius. Mercury was the messenger of the gods, hence the wings. And he was also the god of commerce and gambling; his winged caduceus rightly adorns post offices, stock exchanges, and the more elegant gambling casinos. Ironically, the caduceus of Mercury thus serves as a pretty reminder to American doctors of what they shouldn't do—bear tales, be commercial, and take chances.

Reprinted from address by Alan Gregg, M.D., Rockefeller Foundation, published in the *Bulletin of the American College of Surgeons* with permission of editor and author.

Artificial Eye That Twinkles

An artificial eye, operated by magnets that cause it to move and even twinkle as effectively as the living eye it matches, has been developed at the Veterans Administration hospital in Boston, Massachusetts. The "magnetic eye" already has been implanted in more than 150 patients. The designers are Everett H. Tomb, chief of the eye, ear, nose and throat section, and Donald F. Gearhart, chief of the plastic eye and restorations clinic at the Boston VA Hospital. After 6 years of research, Tomb and Gearhart have perfected a magnetized implant, the magnet of which is placed within clear, nonirritating plastic.

Tomb has provided the surgical technique that permits the implant to become completely buried within the eye socket and to which the muscles of the removed eye are directly attached. Wounded or once diseased eye sockets are then allowed to heal completely over the buried implant before the artificial eye is made.

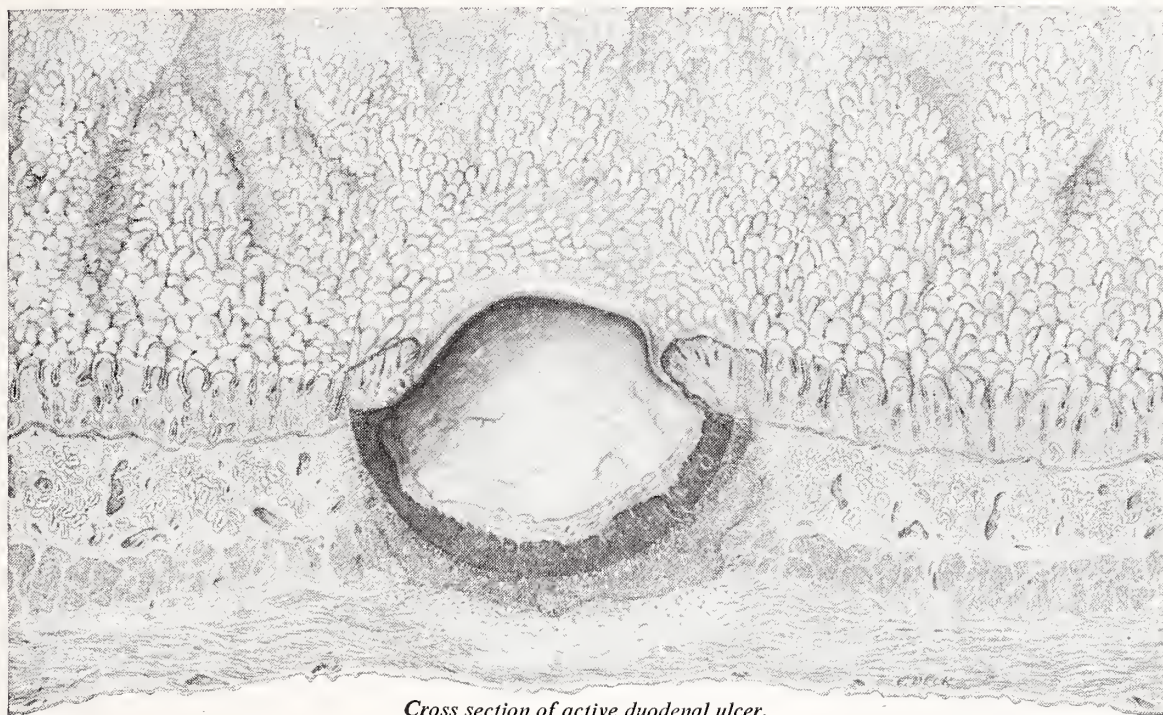
A permanent magnet is set into the artificial eye during its fabrication to match the magnet of the imbedded implant. These magnets are so aligned that the artificial eye cannot slip out of correct, normal position. The magnets provide excellent anchorage for the eye, which relieves the eyelids of the burden of carrying the weight of the artificial eye.

CONNECTICUT HEALTH LEAGUE TO MEET IN BERLIN

A meeting of the Connecticut Health League will be held in the auditorium of the Connecticut Light and Power Company, Berlin, June 22, at 2 P. M.

A review and panel discussion of health legislation will feature the session. Participants in the discussion, titled "A Critical Post-Mortem of the 1955 Legislative Session of the General Assembly," will comprise Harold A. Barrett, M.D., M.P.H., deputy commissioner, Connecticut State Department of Health; John Blasko, M.D., director, Connecticut State Department of Mental Health; Rt. Reverend Monseigneur John J. Hayes, Connecticut Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm; Udell LaVictore, Connecticut State Department of Welfare; Paul Phelps, M.D., medical director, Connecticut Tuberculosis Commission. Fred B. Schuckman, State budget director, will be the moderator.

PRO-BANTHINE® IN DUODENAL ULCER



Cross section of active duodenal ulcer.

Dramatic Remission of Ulcer Pain

Pain of ulcer is associated with hypermotility; the pain is relieved when abnormal motility is controlled by Pro-Banthine.

"In studying¹ the mechanism of ulcer pain, it is obvious that there are at least two factors which must be considered: namely, hydrochloric acid and motility.

"... our studies indicate that ulcer pain in the uncomplicated case is invariably associated with abnormal motility. . . .

"Prompt relief of ulcer pain by ganglionic blocking agents . . . coincided exactly with cessation of abnormal motility and relaxation of the stomach."

Pro-Banthine Bromide (β -diisopropylamino-ethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) is a new, improved, well tolerated anticholinergic agent which consistently reduces hypermotility of the stomach and intestinal tract. In peptic ulcer therapy² Pro-Banthine has brought about dramatic remissions, based on roentgenologic evidence. Concurrently there is a reduction of pain, or in many instances, the pain and discomfort disappear early in the program of therapy.

One of the typical cases cited by the authors² is that of a male patient who refused surgery despite the presence of a huge crater in the duodenal bulb.

"This ulcer crater was unusually large, yet on 30 mg. doses of Pro-Banthine [q.i.d.] his symptoms were relieved in 48 hours and a most dramatic diminution in the size of the crater was evident within 12 days."

Pro-Banthine is proving equally effective in the relief of hypermotility of the large and small bowel, certain forms of pylorospasm, pancreatitis and ureteral and bladder spasm. G. D. Searle & Co., Research in the Service of Medicine.

1. Ruffin, J. M.; Baylin, G. J.; Legerton, C. W., Jr., and Texter, E. C., Jr.: Mechanism of Pain in Peptic Ulcer, *Gastroenterology* 23:252 (Feb.) 1953.

2. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: A Clinical Evaluation of a New Anticholinergic Drug, Pro-Banthine, *Gastroenterology* 25:416 (Nov.) 1953.

SEARLE

SPECIAL NOTICES

SYMPOSIUM ON INDUSTRIAL HEALTH UNITED STATES RUBBER COMPANY Naugatuck, Connecticut, September 22, 1955

2:00 P. M.

Low Back Conditions Found on Pre-Employment Physical Examination as Related to Industrial Liability

David Bosworth, M.D., attending orthopedic surgeon, St. Luke's, New York Polyclinic and Seaview Hospitals; consultant to Orthopedic Department, University of Vermont.

3:00 P. M.

Treatment of Hip Injuries

Frederick R. Thompson, M.D., assistant attending orthopedic surgeon, St. Luke's Hospital, clinical professor of orthopedic surgery, Polyclinic Medical School and Hospital; secretary of the Orthopedic Section of the American Medical Association

4:00 P. M.

Surgical Repair of Severe Industrial Hand Injuries

William Littler, M.D., associate attending surgeon, Roosevelt Hospital, New York; plastic and reconstructive surgery

5:00 P. M.

Hematic and Neoplastic Health Hazards in the Rubber Industry

William Hueper, M.D., chief of the Section of Environmental Disease, National Institute of Health, Bethesda, Maryland

There will be a fifteen minute discussion on these subjects following each paper.

RESEARCH FELLOWSHIPS IN THE FIELD OF MULTIPLE SCLEROSIS AND ALLIED DISEASES

The National Multiple Sclerosis Society has established a limited number of fellowships to encourage promising students and scholars to enter the field of research related to multiple sclerosis and the demyelinating diseases.

Fellowship candidates are free to elect a training institution and sponsor of their own choice. However, all candidates are urged to consider a training program looking toward preparation for a career of research in this broad general area of disease.

TYPES OF AWARDS

Postdoctoral Research Fellowships. These awards will be made to qualified candidates holding a doctorate in medicine or in related fields and afford a basic stipend of \$4,000-\$5,000 per year based upon the academic and professional training of the applicant and the family dependency status involved.

Scholars. Appointment as a Scholar of the National Multiple Sclerosis Society will be made to qualified candidates holding a doctorate in medicine or in related fields and who have demonstrated competence in biological investigation. This award will provide a stipend of \$6,000-\$8,000 per year based upon the academic record, professional training, and research attainments and interests of the applicant.

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and a highly gratifying
"sense of well-being."**

"Premarin" ® — Conjugated Estrogens (equine)

TERM AND TENURE OF THESE FELLOWSHIPS

These awards are usually made for one calendar year and may start any time within eight months of the date of notification of the award. One or two additional years of fellowship support may be requested; however, total tenure is not expected to exceed three years. In all cases additional years of support are dependent upon the terms of the original award and upon continued endorsement by the sponsor.

Application may be made at any time. Awards will be announced twice yearly—in June and in December. All prospective applicants must submit their applications and supporting documents to the NMSS on or before March 1 or September 1.

SPONSORSHIP

Research Fellows and Scholars may undertake their training at any institution qualified to provide such training. It is the responsibility of the applicant to make all necessary arrangements for the conduct of his proposed training program both with his prospective sponsor and the institution.

CONCURRENT AWARDS

These awards will not be made or continued concurrent with other fellowships except under unusual circumstances.

CLINICAL TRAINING

Fellowships awarded by the National Multiple Sclerosis Society are not intended to support the routine clinical

training of a resident where the primary aim of the resident is specialty board certification.

TEACHING BY FELLOWS OR SCHOLARS

Fellows or Scholars of the National Multiple Sclerosis Society are allowed to spend a reasonable amount of their time in teaching.

GRANTS TO THE INSTITUTION TO DEFRAY FELLOWSHIP COSTS

Grants of up to \$500 may be made to the sponsoring institution, upon application, as reimbursement for costs incurred by the institution incident to the training program. Tuition and other usual, related fees are chargeable against this grant.

TRAVEL REIMBURSEMENT

A travel allowance of \$150 will be allowed annually for travel from home to the sponsoring institution or to medical meetings.

Applications may be secured by writing to: Harold R. Wainerdi, M.D., medical director, National Multiple Sclerosis Society, 270 Park Avenue, New York 17, N. Y.

BOSTON CLINICAL MEETING
AMERICAN MEDICAL ASSOCIATION

November 29 - December 2, 1955

All persons who desire a place on the lecture program at the Boston Clinical Meeting of the American Medical

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than other corticosteroids

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of sodium retention
and potassium depletion

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Association are urged to communicate immediately with the Chairman of the Program Committee—Theodore L. Badger, M.D., c/o Massachusetts Medical Society, 22 The Fenway, Boston 15.

Applications for space in the Scientific Exhibit are now available and will be sent on request. Exhibits will supplement the lectures as far as possible, and should portray subjects of a broad general interest. Requests for applications should be sent to the Secretary, Council on Scientific Assembly, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

NEW ENGLAND TUBERCULOSIS CONFERENCE

The fifth in the series of New England Tuberculosis Conferences is scheduled for Monday and Tuesday, September 12 and 13, at the Hotel Wentworth-by-the-Sea, Portsmouth, New Hampshire. Mrs. Lawrence T. Bartlett of New Canaan is President of the Council, and the Program Chairman for the Conference is Miss Marian L. Garland, Laconia, New Hampshire. All tuberculosis workers, volunteers, physicians, nurses, and Association staffs are encouraged to save the dates and attend the Conference.

REGIONAL LEGISLATIVE CONFERENCES

Dates have been set for a series of six regional legislative conferences which the Board of Trustees authorized the AMA Committee on Legislation to sponsor in the fall. Purpose of the meetings is to discuss in detail the many important medical bills pending in Congress.

The fall meetings will be held in six different cities with attendance being made up of representatives from surrounding states.

October 29, New York, Dr. David B. Allman, chairman.

CLINICAL SESSION — 1955 AMERICAN MEDICAL ASSOCIATION

For the first time, all six New England States will be host to the Clinical Session of the American Medical Association this fall. The meeting, held in Boston from November 29 through December 2, will provide another excellent opportunity to maintain this region's well established medical leadership recognized throughout the world.

Abstracts of papers, contained in not over 300 words, should go direct to the Chairman of the Program Committee (AMA), 22 Fenway, Boston; closing deadline July 15, 1955.

Save these dates now, November 29, 30, December 1, 2, 1955, Mechanics Hall, Boston.

NATIONAL GUARD NEEDS MEDICAL OFFICERS

The 43rd Division, a unit of the Connecticut National Guard, is in need of medical officers for various command and staff positions. Any physician licensed to practice or in hospital training within Connecticut is eligible for commission in the Connecticut National Guard and National Guard of the United States, active components of the U. S. Army Reserve.

Duties would include supervision of training of medical soldiers, and performance of professional activities within assigned units. Unit training periods of two hours duration in the evening are held weekly at armories in various towns within the State.

A full day's military pay is earned for each two hour training period. Full pay and allowances for 15 days are provided for attendance at 2 week summer field training encampments each year.

Depending upon age, professional experience, and prior military service, appointments may be made within the division in the ranks of first lieutenant through lieutenant colonel.

All interested physicians are invited to address inquiries to: Division Surgeon, Headquarters, 43rd Division, State Armory, Hartford.

THE TENTH RHEUMATISM REVIEW

The Tenth Rheumatism Review, a comprehensive review of the American and English literature of recent years, is being made available for the first time to the medical profession at cost by the Arthritis and Rheumatism Foundation.

Physicians may obtain their copies of the Review by sending \$1 to the Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 36, New York.

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The 418 page Review is based on material culled from 2,250 medical and scientific papers published in the field of arthritis and the rheumatic diseases over a five year period. Written in straight prose and marked for reference, it was prepared by the Editorial Committee of the American Rheumatism Association, the professional society in the field. The book comes complete with index and bibliography.

OUT-PATIENT CLINIC FACILITIES FOR
HARTFORD

Hartford Health Department

56 Coventry Street—Tel. CH 9-7381

A. 1. IMMUNIZATION CLINIC

- 2. Monday, 9:00-11:00 A. M.
- 3. School children on referral from school nurse. Adults for foreign travel or as contacts to acute cases on referral by private doctors.
- 4. No fees—except for cholera, typhus and plague in which case, fee is cost of vaccine.

B. 1. CHEST CLINIC

- 2. Monday, Tuesday and Friday 9:30-11:30 A. M.
Wednesday 1:30-3:30 P. M.
Pneumothorax and puneumoperitoneum treatment only
Wednesday 9:30 A. M.

- 3. Referral by physicians, Visiting Nurse Association or self.

- 4. No fee.

C. 1. CHEST X-RAY SURVEY CLINIC

- 2. Monday through Friday 1:00-4:00 P. M.
- 3. Referral by physicians, industry, agencies or self.
- 4. No fee.

D. 1. VENERAL DISEASE CLINIC

- 2. Tuesday and Friday 9:00-1:00 P. M.
and by appointment
Tuesday 4:00-6:00 P. M.

- 3. All types of referral including self accepted.

- 4. No fee.

E. 1. WELL CHILD CONFERENCES (PRE-SCHOOL CHILDREN)

- 2. By appointment through V.N.A.
- 3. Eligibility:
 - A. Families on public welfare
 - B. Referral from hospital prenatal clinics, physicians and agencies.
 - C. Self-referral. Eligibility determined by Hartford Health Department social service; V.N.A. on inability to afford private care.
- 4. No fee.

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F. DENTAL CLINIC (PRE-SCHOOL)

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2. Hours 9:00-4:00 by appointment, Monday through Friday
3. Children age 2-6 years eligibility same as for well-child conference.
4. No fee.

Hartford Hearing League

252 Asylum Street—Tel. JA 7-0753

A. HEARING TEST CLINIC

1. Hearing test with the audiometer. Fitting and selection of a hearing aid. Classes and individual instruction for adults and children in lip reading, speech correction, voice improvement and auditory training. Instruction for children includes guidance for their parents.
2. 9:00-5:00 Monday through Friday. Hearing tests and selection of a hearing aid by appointment only.
3. Persons with hearing problems or associated conditions are eligible.
4. Fees: Audiogram only, \$3; audiogram with interpretation and counseling, \$5. Audiogram and hearing aid selection, \$8 to residents of Greater Hartford; \$10 to non-residents. Class instruction fee arranged with Director. Individual instruction \$3 per half hour. All fees to residents of Greater Hartford can be adjusted, based on ability to pay.

Veterans Administration

95 Pearl Street—Tel. JA 7-2641

A. OUTPATIENT CLINIC FACILITIES

1. Outpatient Clinic Facilities, 95 Pearl Street, Hartford, and 355 Fairfield Avenue, Bridgeport, includes complete medical, surgical, x-ray, laboratory, pharmacy, physiotherapy department, and mental hygiene clinic. (No physiotherapy department in Bridgeport.)

Veterans unable to use this facility may be treated by Veterans Administration fee-basis physicians for their service-connected disabilities, with prior VA approval, except for emergencies.

2. Clinic Hours 8:30-5:00 P. M. Monday through Friday
3. Veterans of all wars are eligible for examination at either clinic to determine need for hospitalization (service-connection not a factor).

Veterans of the Spanish-American War are eligible for outpatient treatment for any condition amenable to treatment.

4. No fee.

The Institute of Living

200 Retreat Avenue—Tel. JA 7-3101

A. MENTAL HYGIENE CLINIC

1. Psychiatric service for adults, by appointment, age 18 and over.

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2. Clinic hours: Tuesday, Wednesday and Thursday, by appointment. 9:00-5:00 P. M.
3. Referrals from social agencies of the Greater Hartford area. For information call the Red Feather Information Service or the Mental Hygiene Clinic of the Institute of Living. Initial appointment is made by referring agency.
4. Fees for treatment up to \$5 per visit are based on the patient's ability to pay.

The Hartford Rehabilitation Center, Inc.

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1. A. Physical therapy
 - B. Occupational therapy
 - C. Speech therapy
 - D. Woodworking, testing and training
 - E. Sheltered workshops
(for Cardiac and arrested TB patients)
 - F. Social Services
2. By appointment 8:30-5:00 P. M. Monday through Friday
3. Accepts orthopedic and neuromuscular disabilities. Referrals from physicians, agencies or self-referral. Patients are accepted only by written prescription from their own physician.
4. Patients pay a fee in accordance with their ability to assume financial responsibility.

NEWS

from County Associations

Fairfield

Irving L. Nettleton of Bridgeport, a practicing physician in that city for 55 years, died at his home on April 22. Dr. Nettleton was honored four years ago when the State Medical Society presented him with a 50 year pin.

Hartford

William J. Lahey was elected president of the Greater Hartford Tuberculosis and Public Health Society at its annual meeting in April. Dr. Lahey, who succeeds Dr. Llewellyn Hall, is director of medical education at St. Francis Hospital, Hartford. Norton G. Chaucer of the Hartford Health Department was elected vice president.

Douglas J. Roberts of Hartford, treasurer of the American Radiology Society, and Ralph T. Ogden, chairman of the by-laws committee of the same

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179 ALLYN STREET HARTFORD, CONN.

Society, attended the annual meeting in Washington, D. C. in April.

The Hartford Hospital has opened its first fully staffed outpatient pediatric clinic. This clinic has been made possible by a bequest in the will of Faye Belden Rentschler and is established in memory of Jean Belden Rentschler who died in infancy.

Maurice M. Pike of Hartford was elected president of the Boston Orthopedic Club at its annual meeting in April. Although the Society draws its membership from all six New England States, it is very rare for a president of the Society to be selected from outside of Boston.

J. Whitfield Larrabee of Hartford has been elected president of the Connecticut Rheumatism Association.

Carl S. Hellijas is now president of the Connecticut State Society of Anesthesiologists.

William B. Scoville of Hartford recently completed a tour of South America. He attended the Latin American Neurological Congress in Montevideo, Uruguay, lectured in Buenos Aires, Argentina, visited in Santiago, Chile, Rio de Janeiro, Brazil, Carracas, Venezuela, and in Lima, Peru.

Litchfield

The 191st annual meeting of the Litchfield County Medical Association was held at the Newgate Coon Club, Norfolk, on April 19. The meeting was preceded by a social hour and a delicious steak dinner. Following a discussion of the American Medical Education Fund by James G. Burch, director of public relations of the State Medical Society, a resolution concerning medical education, proposed by the Society's Committee for American Medical Education Foundation, was introduced by Robert Downie. The resolution was adopted without dissent.

Louis Garston presented the following proposed amendment to the Litchfield County Medical Association By-laws: "Meetings—Article 16—Section 1A: The annual meeting, to be held at any suitable place in the county, during the month of March or April, the time and place is to be selected by the Executive Committee. At this time, its principal business shall be transacted and, if possible, the agenda for the annual meeting of the House of Delegates of the State Society be brought to the attention of the members for discussion so that the delegates may be cognizant of the wishes of the Association." This amendment was considered necessary as the fourth Tuesday in April, which is the time stated in our

present By-laws, frequently conflicts with the annual meeting of the State Medical Society, the State Medical Society's meeting having to conform to the school vacation period so that a building large enough to house our ever growing Society can be made available.

The following slate of officers, presented by the nominating committee, were elected by acclamation: President, Richard I. Barstow; Vice President, John F. Kilgus, Jr.; Secretary-Treasurer, Isadore S. Goldberg; Alternate Councilor, Royal A. Meyers (for 1 year).

Executive Committee: John R. Elliott (to serve 3 years); Sidney A. Chait (to fill out the unexpired term of Dr. Meyers of 1 year).

After the election of officers the retiring president, Francis A. Sutherland, gave a most interesting and enlightening talk on the history of the Medical Society in Connecticut, with particular emphasis upon the part played by the Litchfield County physicians. At the conclusion of his talk, Dr. Sutherland expressed his appreciation of the cooperation that had been extended him during his term of office by all the officers and members of the Association.

Middlesex

The annual meeting of the Middlesex County Medical Association was held at Restland Farm in Northford on Thursday, April 14. Officers for the coming year were elected as follows: Willard Buckley, president; Joseph Magnano, vice president; Vincent Vinci, clerk. The speaker at the meeting was Professor Wilbur Frohock of Wesleyan University. New members elected into the society are: James R. Glessner, Jr. who is practicing orthopedics in Middletown, and Kenneth F. Greene who is on the staff at the Connecticut State Hospital.

F. Erwin Tracy attended the annual meeting of the American College of Physicians in Philadelphia at the end of April.


New Haven

Alfred Hurvitz, chief of surgery at the Veterans Administration Hospital, West Haven and associate clinical professor of surgery at Yale University School of Medicine, has been appointed professor of surgery at the State University of New York College of Medicine at New York City.

John R. Paul, professor of preventive medicine at Yale University School of Medicine, is the new president of the Association of American Physicians.

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CONNECTICUT STATE MEDICAL JOURNAL
160 St. Ronan Street New Haven 11, Conn.

Dr. Paul was elected at the annual meeting of the Association held at Atlantic City in May.

New London

At a recent meeting of the New London City Medical Society, held at the Lawrence and Memorial Associated Hospital, officers for the coming year were elected as follows: Joseph Woodward, president; Louis DeAngelis, vice president; Charles F. Dyer, secretary-treasurer. This medical group is presently making plans to cooperate with the local health authorities in administering the Salk Polio Vaccine. Plans are also under way for the annual summer picnic.

At the monthly dinner lecture at the Lawrence and Memorial Hospital, held on April 21, the speaker was Joseph Rogers, physician at the New England Center Hospital and assistant professor of medicine and lecturing gynecologist at Tufts Medical College. His subject was, "Endocrine Disorders in Women."

The regular monthly meeting for April at the William Backus Hospital in Norwich was held April 14. The speaker was Jacob Lerman of Massachusetts General Hospital who spoke on "Advances In Treatment of Thyroid Disease." Dr. Lerman was also available for medical consultation.

The May meeting at the Backus Hospital was held on May 12. The speaker was Perry Culver of the Massachusetts General Hospital on "Hepatitis."

Sidney Drobnes announces the removal of his office to 24 Sachem Street, Norwich. His practice is limited to the diseases of the nervous system.

This seems to be the month for trips and vacations. It is reported that Henry Archambault of Taftville has recently returned from a few weeks in Bermuda. George Gildersleeve of Norwich is on his way to Europe. Edmund Douglass of Groton and Eric Blank of New London have just returned from a trip to the west coast.

At a recent meeting of the Board of Trustees of the New London County Medical Association, a new county medical association public relation committee was formed, consisting of Harold Bergendahl of Norwich, chairman, Hugh Lena of New London, H. Peter Schwarz of Norwich, as members. A new committee on medical ethics and deportment for the coming year was also formed, consisting of Alfred Labensky of New London, chairman, and Edmund Douglass of Groton, John Raymer of Norwich, Mario Albamonti of Norwich, and Roland Hill of Mystic.

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Doctors are invited to inquire about the professional discount which is offered on the purchase of a Sealy Posturepedic for the doctor's personal use only.

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It is with deep regret that we report the death of Clarence G. Thompson, former health officer in Ledyard and Preston and a doctor in Norwich since 1921. He died on May 6, 1955. Dr. Thompson was a pioneer member of the New London County Chapter of the Infantile Paralysis Foundation and served in various capacities, including the office of vice chairman, which he held at the time of his death.

Our sick committee reports that Harold von Glahn is presently resting in the Lawrence Hospital and Demetrius Traggis is a patient at Uncas, and Harold Wellington is convalescing at home. We understand that all three patient are improving satisfactorily.

Windham

Edward J. Ottenheimer of Willimantic, together with Ashley W. Oughterson of New Haven, is the author of "Observations on Cancer of the Colon and Rectum in Connecticut" published in the *New England Journal of Medicine*, April 7, 1955. The paper was read before the New England Surgical Society at its annual meeting in October, 1954.

NEW BOOKS IN REVIEW

ELECTROCARDIOGRAPHY IN PRACTICE. By Ashton Graybiel, M.D., Paul D. White, M.D., Louise Wheeler, A.M., and Conger Williams, M.D. Philadelphia: W. B. Saunders Company. 1954. 378 pp.

Reviewed by CHARLES E. McLEAN

The third edition of this atlas of electrocardiography is now available and has been entirely rewritten to include the unipolar limb and precordial leads, as well as some interpretation of vectorcardiography in clinical practice.

The book is divided into eight parts dealing with physiology, methodology, consideration of the various electrocardiographic leads, rhythm disorders, drug effects, electrocardiographic patterns, records from different etiological types of heart disease, and finally, a series of "unknowns" for practice interpretation. There are 294 illustrations which are exceptionally well done.

The sections on electrocardiographic alterations due to drugs and chemicals, etiologic types, and electrocardiograms for practice in interpretation are particularly helpful to the practitioner, regardless of whether he is a general practitioner or a specialist. The book is well indexed, so that it represents a ready reference with good illustrations of the conventional electrocardiographic changes. It combines the brevity of an atlas with the completeness of a

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text, although none of the sections are dealt with in great detail. For this reason it is easily readable and quite understandable and represents one of the simplest of the many texts available today on this subject.

ELEMENTS OF PEDIATRIC ANESTHESIA. By C. R. Stephen, M.D. Springfield, Illinois: Charles C. Thomas, Publisher. 1954. 109 pp. 24 illustrations. \$3.50.

Reviewed by WILLIAM F. BAUER and RALPH M. TOVELL

Throughout this work one sees evidence of the author's dedication to his subject and his earnestness in conveying his convictions. At the onset the reader is given a concise but searching summary of physiological factors as they specifically apply to pediatric techniques. Particular emphasis is placed upon avoidance of hypoxia and recognition of anatomical variations and limits of tolerance. The monograph deals, in adequate if not exhaustive fashion, with anesthesia for the premature infant, premedication technical methods, anesthetic drugs, and the approach to everyday as well as unusual problems. The two final chapters are devoted to oxygen therapy and the treatment of asphyxia neonatorum.

Dr. Stephen's style bespeaks both thorough familiarity with the topics he treats, and mature thought in their presentation. His exposition is at all times positive, imparting the rewarding feeling that he does not avoid taking a stand on issues open to discussion.

The binding and paper are of good quality, the typography is excellent, the illustrations are clear, pertinent and ample and the references are adequate. While in no sense encyclopedic, this monograph contains an abundance of worthwhile related material, well integrated and conveniently presented. It should have widespread appeal and value to all who undertake pediatric anesthesia.

THE ANNUAL SURVEY OF PSYCHOANALYSIS, Vol. II, 1951. Edited by John Frosch, M.D., et al. New York: International Universities Press, Inc. 1954. 724 pp. \$10.

Reviewed by RICHARD KARPE

The second volume of this survey has been expected for some time. It is published a year and a half later than the Yearbook of Psychoanalysis, 1952, and two and a half years later than any of the surveyed papers. This delay is disturbing because one likes to be informed as early as possible by the survey about the published literature. On 690 pages are found extended summaries of 260 papers and digests of fourteen psychoanalytic books. Twenty-eight other book titles are mentioned. Amongst the important books are: Maria Bonaparte's, *Female Sexuality*; Hans Sachs's, *The Creative Unconscious*; David Rapaport's, *Pathology of Thought*; Franz Alexander's, *Age of Unreason*; and Ernest Jones's, *Nightmare*. The survey is an ambitious attempt to provide extensive information about the psychoanalytic literature published in one year. One can clearly see the experimental and still somewhat tentative approach of the editors. This second volume is a direct continuation of the first volume with the exceptions of a new chapter on dream studies which was introduced due to the revival of interest in dreams, and of a chapter on training and practice which was dropped because the number of papers on this topic has declined. The annual output of papers is quite im-

pressive. I do not know, however, whether the non-English literature is completely covered. Less than ten per cent of the summarized papers were written in one of the Latin languages and only one of the papers was written in German. It certainly is a sign of the times that the historical development which produced in earlier years the major works in psychoanalysis has now taken such a back seat. No paper was written in any of the Slavic languages which was summarized.

One of the most interesting chapters seemed to me to be the chapter on "Critique" by Jacob Arlow, who, among others, surveys Anna Freud's paper, "Observations on Child Development," originally published in the *Psychoanalytic Study of the Child*, Vol. VI. This study is based on a five year observation of the children at the Hempstead Nurseries which were created during the war for evacuated British children. Anna Freud uses a longitudinal observation to re-evaluate the analytic libido theory and publishes nonconfirmatory as well as confirmatory observations. She introduces here a new trend which may go far in the evaluation of the constructions which the analyst deduces from his work with adult patients.

Connecticut analysts are represented here with only one paper, "The Secrer" by Alfred Gross, New Haven, instructor of the Western New England Psychoanalytic Institute and professor at Yale Medical School. This paper was originally published in the *Bulletin of the Menninger Clinic*. It aroused great interest and was reprinted in its entirety in the *Yearbook*.

All papers of the *Yearbook* are represented in summaries except one by Warner Muensterberger on "The Use of Psychoanalytic Concepts in Anthropology." Two other papers of Muensterberger are summarized. This substitution may be due to the fact that this paper was printed originally in the *International Journal of Group Psychotherapy* which is not among the reviewed journals. Another journal which is not included is the *American Journal of Psychiatry*.

The reader of psychoanalytic literature can never read all the psychoanalytic publications and therefore welcomes surveys of this kind to supplement his reading. Some summaries are more digests than summaries which suggests the idea that the survey may for many substitute rather than supplement the reading of psychoanalytic publications. If summaries might have been chosen of the kind done by Braceland's librarians, the publishers could save enough space to bring the next two years into one volume and in that way bring the papers closer to their publication date.

Of special interest for the physician are three of the thirteen chapters. These are: "Clinical Studies" reviewed by John Frosch; "Psychoanalytic Study in Psychiatry" reviewed by Charles Brenner; "Psychoanalytic Studies and Psychosomatic Medicine" reviewed by Sidney Tarachow. In the chapter, "Clinical Studies," thirty-three papers are summarized of which one-third contain papers on psychosis, another third on neurosis, and the last third on personality problems and criminology. Seventeen papers are summarized in the chapter on "Psychosomatic Medicine." The differences between the specialist in psychoanalysis and specialists in other branches of medicine here step to the background and a greater cooperation is achieved. But the danger of confused and misunderstood concepts increases as well. Only a relatively small number

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of papers out of a host of writings were selected. That selection was dependent on the contribution that that particular paper could make towards our thinking. A panel which handled many challenging problems produced among others Alexander's paper on new research efforts and his suggestion of blind diagnosis. Another very interesting paper is Margolin's work on Helen, the girl with the gastric fistula, paying special attention to synchronous gastric behavior versus a dissociation of gastric activity.

No scientific worker in this field can be without this book.

STELLATE GANGLION BLOCK. By Daniel C. Moore, M.D. Springfield, Illinois: Charles C. Thomas. 1954. 280 pp. 101 illustrations. \$10.50.

Reviewed by MATTHEW BAZOIAN and RALPH M. TOVELL

Readers of Dr. Moore's earlier book on regional anesthesia will be surprised that the short chapter on stellate ganglion block has been expanded into a book of 280 pages. Lest they be discouraged by the length, however, the book which is well written and illustrated may be read easily in its entirety. It is so organized that parts may be read for specific reference. Much information may be gained of a practical and theoretical nature. The author's stated purpose is "to stimulate the interest of physicians in the usefulness of stellate ganglion blocks in various disease entities and to encourage them to learn one of the techniques for performing it."

There are three chief divisions in the book. Part One deals with general considerations of fundamental techniques, equipment, drugs, management, anatomy and physiology. Of particular merit is the anatomic review with excellent diagrams, many of which are of original dissections by an anatomist. It is stressed that a stellate injection involves blocking the "cervico-thoracic sympathetic nervous system" by spread of the solution into the upper thoracic and lower cervical areas. This is convincingly illustrated by roentgenogram taken following injection of diodrast in living patients. Further evidence of spread is offered by illustrations of dissections of bodies of persons recently deceased. The dissections were preceded by the injection of latex compounds in the region of the stellate ganglia. The roentgenographic technique for control of stellate block is described, its hazards noted, but throughout the book the author urges its use whenever the evaluation of the block becomes most important in determining future therapy including operation.

Part Two is a relatively small section dealing with techniques, signs and symptoms, and complications of stellate ganglion block. Wisely the author emphasized the safety of the anterior approach which he uses, and relegates the alternate techniques which would only confuse the beginner to a short appendix. The various complications are adequately considered and their infrequency is stressed. Although the author has had no fatalities in over 2,000 injections, the reported mortality rate, in a large survey, of 0.1 per cent should discourage the reckless application of this block.

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Part Three, which constitutes one half of the book, contains a collection of medical and surgical diseases in the presence of which stellate blocks have been done with varying degrees of success. This section will prove to be the most controversial. It is doubtful that many physicians will use this block as an adjunct in the treatment of tuberculosis, migraine, peptic ulcer or asthma, to mention a few. The confusion of reports only confirms the opinion that better controlled studies must be made before the efficacy of sympathetic block can be determined. The author does not ignore the inconsistencies of its more enthusiastic advocates. He presents an extensive review of the literature and takes a partisan role when his own experience justifies it. His clinical description of diseases such as the sympathetic dystrophies and the many varieties of vascular occlusive processes should encourage more frequent recourse to this technique as an adjunct to therapy. This section should be of real interest to surgeons and internists who have lagged behind their European confreres in utilizing this form of therapy. The anesthesiologist will benefit from this knowledge in his consultant role, on the one hand, by urging proper use of diagnostic or therapeutic blocks and, on the other hand, by cautioning against indiscriminate and futile trials of the method. A useful technique can thus be prevented from falling into disrepute.

THE CLINICAL INTERVIEW. VOLUME I. DIAGNOSIS; A METHOD OF TEACHING ASSOCIATIVE EXPLORATION. By Felix Deutsch and William F. Murphy. New York: International Universities Press, Inc. 1955. pp. 613. \$10.

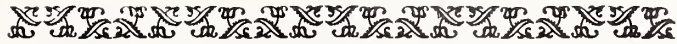
Reviewed by FRANCIS J. BRACELAND

This book is intended chiefly for the teaching of psychiatric residents and for those interested in improving their own approach to skillful interviewing and to psychotherapy. Emphasis is placed upon the cultivation of an awareness in the student of what is going on in the treatment situation between the patient and himself.

In the first chapter an interviewing technique, designated "Associative Anamnesis," is discussed in detail. While the concept is based upon free association as used in psychoanalysis, the emphasis is different and the author believes that when this type of history taking is properly utilized the therapist will learn how the symptoms developed and what they meant to the patient from early childhood.

An outline of the interview is given (p. 26) and in succeeding chapters various syndromes are considered. Chapter 6 discusses the use of the associative anamnesis technique in psychosomatic illnesses. Other chapters detail verbatim interviews with introductory material reviewing briefly some of the essential theoretical concepts which the interviewer should keep in mind during the course of the treatment, the final discussion and the follow-up.

The authors stress the necessity for careful listening to the words of the patient with a view to understanding the meaning behind the words. They advocate what they call "Sector Psychotherapy," i.e., the application of psychoanalytic principles to a limited section of the patients' lives. The book is the first of two volumes. The second will deal with various other aspects of the interview and



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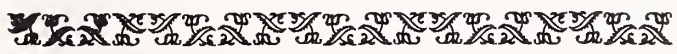
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treatment including the termination of therapy. Psychiatrists and psychiatric residents will be interested in these volumes.

THE PSYCHIATRIST AND THE DYING PATIENT.

K. R. Eissler, M.D. New York: International Universities Press, Inc. 1955. pp. 338. \$5.

Reviewed by FRANCIS J. BRACELAND

The author of this volume sets forth his ideas and describes his techniques for handling the problems of dying patients. The book is interesting, mainly because it covers many aspects of the meaning of death to various individuals and its place in their own psychology. Three detailed case histories are given describing the thoughts and feelings of dying patients and describing how the author attempted to assist them in preparation and in meeting their needs.

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He states that in his last days man may achieve a degree of individualization which he had been unable to attain before.

The "death instinct," as conceived by the Freudian system, is considered in detail and the author expresses the belief that man is only kept from death by the development of a strong ego structure. Knowledge of death, he says, is one of the frustrations producing growth; without it and without an attempt to evade it, man might become completely inactive.

Dr. Eissler sees the maintenance of life on the pleasure principle and he believes that the ego necessarily succumbs when all potential avenues of pleasure are closed to it. He illustrates this point by a discussion on the death work of Beethoven.

The writer expresses a hope for the development of a science of orthothanasia or dying in a manner adequate with the reality of death. As might be surmised, there will be some agreements and much more disagreement with the author's ideas and his thesis.

Whether or not psychiatry has any place at all in this period is indeed a moot point. The book is well written and provocative but there are many who will not be convinced by it. One doubts that the dying patient will be anxious to see a psychiatrist unless he is present at that time in the role of friend or skilled physician.

THE ADOLESCENT EXCEPTIONAL CHILD, A REALISTIC APPROACH TO TREATMENT AND TRAINING. Langhorne, Pennsylvania: Child Research Clinic of The Woods Schools. 1954.

Reviewed by FRANCIS J. BRACELAND

This pamphlet, published as a public service, is a report of the third conference in a series on "The Exceptional Child from Birth through Adolescence," sponsored by The Wood Schools. Held in New Orleans in the spring of 1954, the conference dealt with the problems of retardation in adolescence.

The three sessions, the proceedings of which are reported in full, focussed on helping the retarded adolescent to become a socially accepted, economically adjusted member of the community through his own resources and skills. The first two sessions were devoted to speeches on evaluation and selection of the retarded child for training, on job opportunities, and on school curriculum. The third session was a panel discussion of practical problems in occupational placement of the retarded child from the point of view of parent, church, business and industry, pediatrician, guidance agency, educator, and organized labor. A question and answer discussion followed. The pamphlet concludes with a list of publications distributed by the Child Research Clinic of The Woods Schools. These and the one reviewed are available without charge.

Since it is estimated that about two million school age children in this country are intellectually retarded, the need for continued research and increased interest and knowledge concerning the welfare of the exceptional child is obvious. The material presented here by well qualified persons should be of interest not only to those working in the field but to all thoughtful citizens.

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THE HUMAN MACHINE. By Charles W. Shilling, Captain, Medical Corps, United States Navy. *United States Naval Institute: Annapolis, Md.* 292 pp. \$5.

Reviewed by ROBERT M. KNOWLES

The Human Machine is a medical textbook which was originally written to replace a long outdated volume of hygiene used by the midshipmen at the United States Naval Academy. Fortunately, its general appeal was recognized and now, in addition to being used by servicemen in all branches of the Armed Forces, it has been made available, by the Naval Institute, to the general public as well.

Although the author is a physician, it is written with an engineer's approach and is gently salted with naval terms, both of which give the book a most unique and appealing flavor. The tables and illustrations, of which there are many, are pertinent and imaginatively done. There are simple and concise chapters on anatomy, physiology, pathology, preventive medicine and warfare medicine, which are both authoritative and up-to-date.

Warfare medicine includes sections discussing sanely, atomic, biological and chemical warfare; ABC's of extreme importance to all of today's potential targets.

Unlike the volume of Naval Hygiene that was handed out to Naval Academy plebes at the start of the academic year and never opened, this book, because of its engaging style, never condescending, never too technical, will be read and thoroughly enjoyed by future naval officers, servicemen and civilians.

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MEDICAL PARASITOLOGY AND INTERNAL MEDICINE

THOMAS T. MACKIE, M.D., *Westport*

The Author. *Consultant, Internal Medicine, Tropical Medicine, Roosevelt Hospital, New York City; Norwalk Hospital, Norwalk, Connecticut; and Veteran's Administration Hospital, West Haven, Connecticut*

INFECTIONS by protozoan and metazoan parasites are generally considered to have little importance in the practice of medicine in the Northeastern United States. Consequently, the curricula of medical schools and schools of medical technology devote relatively little attention to instruction in medical parasitology. These infections are seldom considered in differential diagnosis and few clinical laboratories are prepared to give expert diagnostic assistance. However, it is probable that diseases included in this category will assume more importance in the future.

The economy of this country is becoming increasingly dependent upon sources of essential raw materials outside the North American continent. The international responsibilities of the United States require foreign service in many areas of the world for large numbers of our young people in the armed forces and for others in ancillary services. The greatly increased transportation facilities and the development of the tourist trade in many regions have greatly stimulated travel to overseas areas in many of which these diseases are heavily endemic. Exposure to infection, therefore, is frequent. Instances of tropical and parasitic diseases are not rare among people who have traveled extensively in the poorly sanitized regions of the world.

However, not all parasitic infections are acquired abroad. The determining factors in many instances are local conditions of hygiene and sanitation rather than climate or the availability of suitable vectors

SUMMARY

Only two of the important parasitic diseases of man are known to be endemic in the New England States—amebiasis and trichinosis. The true prevalence of *Endamoeba histolytica* in this area is unknown since no competent surveys have been reported. It is probable, however, that infection occurs more frequently than is generally believed, and that the majority of cases are masked by the lack of striking intestinal symptoms and the predominance of atypical and secondary clinical manifestations. Trichinosis is unquestionably more common than is generally appreciated, since postmortem findings indicate an infection rate of approximately 16 per cent. Here again it is probable that the majority of cases are mild, lack the characteristic symptomatology of the severe case, and consequently are unrecognized.

A relatively large group of the population who have lived or traveled in foreign countries have been exposed, to a greater or lesser degree, to many potential parasitic diseases endemic in unsanitated regions and in the tropics but which do not occur naturally in the northern temperate zone. These infections frequently are chronic and long standing, lacking in dramatic characteristics. Obscure illness encountered in individuals in six groups of our population should arouse suspicion of chronic nonendemic parasitic or tropical disease: persons who have served overseas with the armed forces, and foreign service personnel of the Government; corporation officers and employees whose business activities have taken them outside the United States; Foreign Mission Board personnel who have worked abroad; the increasing number of tourists; and, finally, foreign-born individuals who have emigrated to this country. The detailed geographical history of a patient belonging to any of these categories may be of invaluable assistance in differential diagnosis.

Presented before the Regional Meeting of the American College of Physicians, Hartford, Connecticut, October 22, 1954

and intermediate hosts. The parasites of man known to be endemic in the New England region include the pinworm *Entorobius vermicularis*, the amebae *Endamoeba histolytica* and *Dientamoeba fragilis*, the flagellates *Giardia lamblia* and *Trichomonas vaginalis*, and the pork worm *Trichinella spiralis*.

Pinworm infection is widespread. It occurs predominantly in young children, reaching a peak of prevalence among children of school age. It is particularly prevalent among institutional groups and among the family members of an infected child. The eggs are extremely resistant to adverse environmental conditions. They have been recovered from various locations in the domestic environment, including house dust, sweepings from floors and stairways, on children's toys and play garments, and even from laundered underwear. Many of these eggs have been shown to contain viable and infective larvae.¹ Eradication of this infection both in the home and in institutions is notoriously difficult.

Amebiasis, although less common, is probably the most important of these infections. The more authoritative estimates of the overall prevalence in the United States vary between five and ten per cent (Craig),² and approximately 20 per cent (Faust).³ Comparatively little factual information is available for the New England States. A survey conducted some years ago revealed a prevalence of 1.4 per cent among 2,750 Dartmouth College students, and no instance of infection among 205 local rural residents.⁴ Reports to the United States Public Health Service for the years 1938-1939 indicated the following prevalence rates per 100,000 of population:

Maine	0.2
New Hampshire	0.0
Massachusetts	0.6
Connecticut	0.3
No cases were reported from Rhode Island	

Consolidated figures for the New England States based on reports to the United States Public Health Service for the period from 1933 to 1947 included a total of 244 cases of amebiasis with 24 deaths. In commenting on these data, Wright⁵ has stated that they do not represent an accurate appraisal of the occurrence of the disease, and that the cases on record probably represent only a limited proportion of the actual cases.

The true prevalence of amebiasis in this part of the country, therefore, is a matter of speculation. In view of the diagnostic difficulties, it is probable

that it is much more common than available statistical data would seem to indicate. Unfamiliarity with medical parasitology is widespread, and is well illustrated by the surprising statement in an official publication that: "The presence of *E. histolytica* cysts does mean the presence of an active infection."⁶ The problem is further complicated by the fact that the clinical phenomena associated with infection by *Endamoeba histolytica* are extremely variable. It is well established that two general races of the parasite occur, a small strain frequently encountered in this country, commonly associated with only mild symptoms and rarely complicated by dysentery or involvement of the liver; and a large race of much greater potential virulence. The latter is relatively infrequent in the United States.

The usual infections encountered in this country are easily missed since they do not conform to the common textbook descriptions. Furthermore, the generic term "amebic dysentery," by definition, is misleading. Dysentery as such is rare and may well be regarded as a complication rather than as a characteristic feature. The usual type is the so-called cyst passer or carrier, which represents a low grade chronic infection characteristically presenting atypical symptoms of such nature that the diagnosis of psychasthenia or psychoneurosis is often made. The associated symptomatology is frequently dominated by irregularity of bowel function with constipation predominating, although interrupted irregularly by occasional brief periods of loose stools. Flatulence and vague abdominal discomfort, which is more apt to be general than localized, are common complaints. Lassitude and undue susceptibility to fatigue are usual, and there is often intolerance to fats and alcohol in the diet. This syndrome frequently leads to a clinical diagnosis of chronic cholecystitis which, however, cannot be confirmed by x-ray examination. Some degree of irritability and emotional instability frequently occur and tend further to lead the clinician into the field of the psyche rather than the somatic. When it is noted on physical examination that there is some distention of the cecum and ascending colon, especially if even mild tenderness is elicited on palpation, suspicion of the possibility of amebic infection should be aroused. However, this sign is by no means always present, and the symptom complex may be completely atypical and even bizarre at times. One must accept as axiomatic that there is no specific clinical picture. Perhaps the most useful rule of thumb for the practising physi-

cian is to keep in mind that the combination of chronic low-grade abdominal symptoms, which do not fit the picture of any definite syndrome, accompanied by negative results of usual diagnostic procedures should suggest the possibility of amebiasis and indicate the need for competent examination and elimination of this diagnostic possibility before the patient is labelled as a psychoneurotic. Unfortunately, x-ray examination including the barium enema seldom yields helpful findings. Irritability of the colon may be demonstrated, but it is seldom possible to obtain evidence of ulceration.

Etiological diagnosis and the administration of specific therapy is important, not only from the point of view of relief of the patient's symptoms. The *Endamoeba histolytica* is invariably a true parasite which invades the tissues of the host even though the accompanying symptom picture may be mild and apparently trivial. Some degree of ulceration and invasion of the bowel wall almost certainly occurs in every instance of infection. Craig⁷ has stated: "The theory that *Endamoeba histolytica* can live indefinitely in the lumen of the intestine of man without producing lesions by the invasion of the tissues is negated by abundance of evidence. Even though no definite symptoms accompany its presence, it is essentially a tissue parasite and cannot live for any considerable period of time in the intestine or elsewhere in the body without producing lesions;" and further: "The pathology of amebiasis as it occurs in carriers . . . differs only in degree from that present in patients suffering from amebic diarrhoea and dysentery." It follows, therefore, that even though the infected person may be relatively asymptomatic, or may present only trivial symptoms, the risk of serious illness remains so long as the infection persists.

One must assume that amebiasis may be acquired in any region where local conditions of sanitation permit the direct or indirect contamination of food or drink by human excreta. Such exposure to infection is undoubtedly more widespread in certain other parts of the world than in the United States.

Although the figures are not applicable to New England, data obtained by the writer in North Carolina demonstrate the importance of geographical experience of the particular patient. Three groups of individuals were studied to determine the prevalence of intestinal parasitic infections: a random, unselected, statistically valid sample of the urban and rural population of Forsyth County,

comprising 2,543 persons; a selected and, by definition, a statistically biased group of 3,773 patients at the North Carolina Baptist Hospital in Winston-Salem; and a similarly biased group of 1,220 veterans of World War II seen in the Tropical Disease Clinic of the Veterans Administration. The prevalence of *Endamoeba histolytica* was lowest in the random sample of the local population; it was intermediate in the hospital group; and it was well above the usually accepted prevalence level for the United States in the group of veterans.⁸ The observed prevalences are shown in the accompanying table:

PREVALENCE OF *Endamoeba Histolytica*

	NUMBER	
	EXAMINED	PER CENT INFECTED
Forsyth County Survey.....	2,543	8.7
N. C. Baptist Hospital patients.....	3,773	11.4
Veterans Administration Clinic.....	1,220	27.4

To modify Connel's⁴ statement and to amplify its implications, it may well be said that amebic infection depends both upon how one lives and where one lives.

The other intestinal protozoa which are endemic in this region are relatively unimportant. Although *Dientamoeba fragilis* is often associated with loose stools, it is not a tissue parasite and is not a cause of serious disease. Similarly, the flagellate *Giardia lamblia* is of doubtful pathogenicity.

The *Trichomonas vaginalis* is too well known to the general practitioner and the gynecologist to merit discussion.

The parasitic nematode, *Trichinella spiralis*, the etiologic agent of trichinosis is both relatively common and important. Numerous surveys of post-mortem material have shown that this parasite is demonstrable in approximately 16 per cent of all necropsies in this country.⁹ The prevalence is high in the northeastern states, and particularly where the feeding of uncooked garbage to hogs is widely practiced.

The clinical manifestations of trichinosis vary appreciably, and undoubtedly many light infections are unrecognized. However, it may be a serious condition. The average mortality is from five to six per cent. The typical clinical picture of gastrointestinal symptoms, suborbital edema, fever and myositis may or may not be present, and not infrequently the differentiation from other infectious diseases may be difficult.

Although infected pork may be rendered harmless by freezing at low temperatures for sufficient periods of time, this is not a practicable procedure for the packing industry. Federal meat inspection does not insure against this infection. Thorough cooking of all pork products is the only completely effective safeguard for the consumer. A potential source of danger, seldom appreciated, is undercooked ground beef which may be deliberately mixed with pork or accidentally contaminated by infected pork previously put through the butcher's grinder.

It is evident that only a small number of parasites of man are endemic in the New England States and that of these, only two, the *Endamoeba histolytica* and *Trichinella spiralis* may be the cause of serious disease. However, when the number and variety of the parasitic infections which may be acquired abroad are also considered, the total number and variety of the resulting clinical problems are much increased. Since many of these infections are long-lived in the human host, and since they are frequently productive of chronic rather than acute symptoms, the clinical pictures are seldom dramatic. Furthermore, the infrequency of typical textbook syndromes and the problems involved in reaching a definitive diagnosis may lead to erroneous interpretation. Although no figures are available to support a positive statement, it is highly probable that greater attention by the internist to the possibility of parasitic disease might yield results of importance to the community.

In effect, these cases might be classed in the category of geographical medicine. Therefore the travel history of the individual presents important clues to the diagnostic possibilities. Tropical or parasitic diseases acquired outside the United States may be encountered in members of five groups of our usual community populations: young men and women who have had overseas service with the armed forces, and foreign service employees of the government; company officers and employees whose duties take them into foreign countries; personnel of the various Boards of Foreign Missions; the constantly increasing numbers of tourists; and, finally, foreign born persons who have migrated to and settled in the United States.

The problems and responsibilities devolving on the physician in the face of one of these diseases may be both difficult and varied, at times extending well beyond the conventional limits of the practice of

medicine. Certain of these are illustrated by the following case citations.

CASE CITATIONS

1. Veteran; problem: medical and hospital costs to the family.

A World War II veteran who participated in the campaign on Leyte in the Philippines developed what appeared to be a mild infection by *Schistosoma japonicum*. He was intensively treated in an army hospital in the Pacific area, and subsequently invalided to the United States where additional hospital treatment was given. Prior to discharge from the hospital and separation from the service, repeated examinations failed to reveal schistosome eggs, and since he was symptom free he was separated without disability.

Three years later symptoms of increasing intracranial pressure appeared, and since there was no service connected disability, he was sent into a civilian hospital where ultimately a diagnosis of brain tumor was made. Exploration revealed a nonremovable granulomatous mass. A section removed for microscopic examination was reported as non-specific granuloma of the brain. Death finally occurred after many weeks of hospitalization.

The family were in the tenant farmer class without adequate financial resources. Application for assistance to the Veterans Administration was denied on the grounds that the cause of death was nonservice connected. Review of the case by higher authority and examination of the histological preparations revealed lesions characteristic of cerebral schistosomiasis.

2. Veteran; late complication of amebiasis.

An overseas veteran of World War II was seen in the Tropical Disease Clinic of the Veterans Administration. The symptom complex was rather vague and indefinite, characterized by weight loss, loss of sense of well-being, vague abdominal discomfort, flatulence and excessive fatigability. Bowel function was generally normal although occasionally there would be an unexplained brief period of loose stools. He had had no significant illnesses in the service and was separated without disability.

Stool examinations revealed considerable numbers of cysts of *Endamoeba histolytica*. Hospitalization in a Veterans Administration Hospital was finally accomplished, but since the hospital laboratory was unable to confirm the diagnosis, no treatment was given and the patient was discharged. At that time he was urged to enter a civilian hospital for intensive antiamebic therapy. This was refused.

Three years later an acute illness occurred characterized by progressively rising fever, increasing pain in the right upper quadrant accompanied by tenderness and a considerable leucocytosis. At this time a large amebic abscess of the liver was found. Recovery was uncomplicated under specific drug therapy and closed drainage of the abscess cavity.

3. Outbreak of trichinosis; responsibility of physician in a civil action.

Following an outbreak of several cases of trichinosis in a nearby State, a civil suit involving large monetary damages was brought against the local butcher. This individual

and his family operated a farm and butcher business distributing meat and meat products through the local countryside. Cattle and hogs were purchased locally and only a small proportion of the products which he handled were obtained from packers.

The complaint was limited to the single statement by the plaintiff that he had purchased a fresh pork liver from the defendant which was served to the family. Shortly thereafter two of the members of the family became seriously ill. They were hospitalized in a nearby city where ultimately a positive diagnosis of trichinosis was made by histological examination of muscle biopsy material.

Trial was held before a jury. Witnesses for the plaintiff established beyond question the sale of the pork liver by the defendant, but no evidence was introduced that the plaintiff had purchased other pork products. Medical experts testified to the accuracy of the diagnosis, described the life cycle of the parasite, and discussed the epidemiology of the disease. The plaintiff's entire case rested on the statement that the infection was acquired from ingestion of the pork liver.

The defense attorneys called on witness, a physician trained in medical parasitology. It was brought out that trichinosis cannot be acquired from pork liver, however heavily the animal may have been infected, since the larval forms of the parasite which pass through the liver are noninfectious and develop into the infective stage only in the striated muscle of the host.

On the basis of this testimony the presiding judge ordered a directed verdict for the defendant. Had the medical experts for the plaintiff had more complete knowledge of the biology of the parasite and advised counsel, it is probable that the purchase and consumption of other pork products would have been the basis for the plaintiff's suit.

4. Responsibility of a physician in a suit for civil damages based on claim of permanent and total disability resulting from alleged cerebral malaria.

An employee of a shipping company operating between the United States and certain areas of the tropics where malaria is highly endemic developed malaria at sea despite the fact that atabrine was constantly available to the crew, and they had been instructed to follow the suppressive routine recommended by the armed forces during the war. The plaintiff claimed total disability as the result of extensive damage to the brain due to cerebral malaria. He alleged culpable negligence on the part of the company, since the vessel did not have a ship's doctor, and consequently, according to him, treatment of the malaria was incompetent.

Various examinations in advance of trial established a number of facts. The plaintiff was seen in the course of the illness by a physician well versed in tropical medicine. Although it was not possible to examine blood smears, it was the opinion of the doctor that the patient, in fact, did have acute malaria but not cerebral malaria, and further, he responded promptly and completely to therapy. There was serious doubt that the plaintiff had actually followed instructions concerning regular dosage of atabrine.

On his return to the United States he was hospitalized for a malaria relapse. At this time blood smears on two occasions revealed malaria parasites, one report stating that

they were *Plasmodium vivax* and the other that they were *Plasmodium falciparum*. It further appeared that the man was a chronic alcoholic with several hospital admissions for alcoholism. Examination by several neurologists established beyond contradiction the fact that he did have a disabling disease of the central nervous system and, in at least one instance, the examining physician stated that this was almost certainly the result of acute malaria.

The position of the defense was difficult. The diagnosis of malaria was established. One blood smear was said to show *Plasmodium falciparum*, the form of malaria associated with cerebral involvement. Although there was a suspicion that the disease of the central nervous system was, in fact, Huntington's chorea, it was evident that this could not be proved in court. Since the vessel did not carry a ship's doctor the claim of inadequate treatment of the acute attack of malaria was difficult to contradict effectively before a jury.

A group of recognized authorities in tropical medicine were called as medical experts for the defense. They were in agreement with respect to two fundamental aspects of the case: that it was highly improbable that the central nervous system pathology had any relationship to the malaria; and that the verdict by the jury might hinge on the answers to one question by the plaintiff's attorney: "Were the medical experts prepared to state categorically that under no circumstances could the attack of malaria have played a part in the development of the plaintiff's disability?"

RESULT: Since a very large sum of money was involved, the insurance carriers decided to compromise and the case was settled in the course of the trial for a substantial sum, but considerably less than that demanded by the plaintiff.

This was a highly important case since, apart from the financial aspects, it had potential bearing on compensation law, since the claim was based on the results of illness rather than injury. The physicians who were concerned with the various aspects of the case prior to litigation carried greater responsibility than they probably appreciated. There was a high-grade probability that erroneous identification of the malaria parasites was made in the hospital. The clinical history was more indicative of *vivax* than of *falciparum* malaria. The former type is not associated with cerebral complications. The neurologist who stated that the cerebral pathology was the result of malaria was not justified by his training and experience in expressing an opinion concerning the pathologic effects of malaria. And finally, the experts for the defense could not in good conscience categorically state, in view of the evidence available, that the plaintiff's condition could under no circumstances be attributable to the antecedent malaria.

5. Responsibility of a physician concerning impending forced retirement of a senior business executive for chronic disability.

A middle-aged officer of a corporation operating in the tropics had, for a number of years, made frequent visits to the overseas properties of the company. In the course of the preceding two or three years he had gradually but progressively lost weight and strength. His efficiency was seriously impaired and episodes of syncope occurred and increased in frequency.

He was repeatedly examined by competent internists but no definitive cause of the condition could be established. Finally the diagnoses of neurasthenia and male climacteric were accepted.

In view of the extensive time spent in the tropics the patient and his associates in the company decided to have the possibility of some unrecognized chronic tropical infection explored. Within forty-eight hours a heavy infection by *Endamoeba histolytica* was found.

RESULT: Despite the fact that the patient had never had an attack of dysentery or of recurrent diarrhoea, and that he had no significant gastrointestinal symptoms, it was thought that the amebic infection might be a factor in the chronic asthenia. Consequently, specific treatment was administered and he was discharged after twelve days of hospitalization. In the ensuing three months he gained thirty pounds in weight, recovered his normal sense of well-being and energy, and resumed and continued effectively in his responsible position in the company.

The clue to the solution of this clinical problem lay in the geographical history of the patient, and the true nature of the condition was effectively masked by the lack of what are usually considered typical symptoms and signs.

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SALVAGING THE INJURED HAND

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I. INTRODUCTION

The hand controlled by the brain is a most important part of the body. As a wonderful machine tool, it builds the structure and objects of our present day civilization. Through its sensory pathways it sends vital messages to the brain for storing knowledge of form, shape and texture. It aids the speaker in explanation; hand language is more universal than esperanto.

It is a complicated "machine" with over 250 named parts. For example it required the action of 27 muscles to pinch the thumb against the index finger. This valuable "machine" is injured more frequently and has more disability and economic loss than any other part of the body, 70 per cent incidence in the manufacturing industry, for example. As physicians caring for patients with hand

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SUMMARY

The author gives the incidence of the frequency of injuries to the hand and stresses the importance of immediate care if possible. An history of the accident including the time is important. Functional test should be done before the operation. Details of operative and postoperative care are furnished and treatment of fractures, tendon and nerve injuries, and reconstructive surgery is outlined.

injuries we can well strive to reduce the disability, unhappiness, and economic loss from hand injuries.

Presented at 29th Clinical Congress, Connecticut State Medical Society, New Haven, September 16, 1954

II. IMMEDIATE CARE OF HAND INJURIES

The aim of initial care of the hand injury is control of hemorrhage, prevention of additional contamination, infection, and trauma. All of this is simply accomplished by placing the injured hand in a sterile compression dressing with a splint. Hemorrhage is thereby controlled by the gentle compression—even that from a severed radial artery. The sterile dressing protects the open wound from the pyocyanus and streptococcus bacteria of interested bystanders or unsterile instruments. The splint and dressing immobilize the hand, thus preventing added tearing, separation or piercing of damaged tissue.

III. DEFINITIVE CARE OF HAND INJURY

The “When, Where, and How” information will tell the surgeon how long ago the injury happened and if there is still sufficient time interval (4-6 hours) to convert the open contaminated wound to a clean one. The place where the accident occurred will give further index as to contamination—did it happen in the manured farm field or in the relatively clean area of the household kitchen? The manner of injury will give index as to the type of wound and the severity of crush which may be present.

Inquiry as to first aid treatment gives further index as to possible added contamination and trauma.

Diagnosis prior to the patient entrance into an operating room is limited to functional testing rather than examination of the wound. Can the patient flex the distal joint of the finger against resistance; if not, likely the profundus tendon is cut. Can the patient perceive the touch of a cotton applicator to the digit surface; if not, perhaps the digital nerve to the area has been severed or severely contused. Can the patient extend the last two joints of his fingers, spread his fingers apart and bring them together; if not, likely the motor ulnar nerve has been damaged. Can the patient bring the thumb out as in the position of reaching for a glass; if not, likely there is damage to the median motor nerve. All of these tests can be carried out without removing the gauze covering the wound.

If history and functional testing indicate possibility of fracture or dislocation, x-ray can be taken without disturbing the dressings. Only with masked nose and mouth and sterile gloved hands in operating room conditions can aseptic adequate wound examination be made.

In the operating room under its aseptic conditions with adequate appropriate instruments (“eye instruments” and mosquito forceps), sufficient assistance, good lighting, a bloodless field secured by pneumatic tourniquet, and complete anesthesia, preferably general, appropriate treatment can be carried out. The area about the wound is gently cleaned by saline irrigation. Instruments remove devitalized tissue and foreign bodies. If the time interval of Friedrich’s Law permits, severed structures may be repaired and the wound closed primarily. The highest goal of immediate definitive care of hand injury is healing without infection. Where surface tissue has been lost, a skin graft often permits closure without tension. A voluminous gentle compression dressing is applied and the hand and forearm splinted in optimum position with metal or plaster fixation.

Postoperative elevation and rest of the hand promote healing. Noninterference with the initial dressing (6-10 days) permits undisturbed healing. Evidence of complication is early indicated by the signs of temperature, odor and pain in that sequence when infection supervenes. Gangrene as indicated by pain, odor, and temperature (TOP and POT).

When structure healing has occurred, active motion is initiated. (Uninjured portions are started in motion even prior to this.) In general, 10 days for skin and subjacent tissue, 2-3 weeks for muscle, fascia, and capsule, not before 3 weeks for tendon and nerves. Passive motion under direction may be instituted priorly.

Contusions, burns, and wringer injuries are cleansed and vaseline gauze and compression dressing applied with hand on a splint in a position of function. At dressings 10 days later any open areas covered with skin graft and/or devitalized tissue is removed.

Fractures are correctly treated in simple fashion. Too often they are over treated with resulting complications. The position of function will accomplish reduction and proper position for splinting in all phalangeal and metacarpal fractures of the hand (except Bennett’s, boxer’s and baseball type fractures). The dorsal “bowing” of metacarpal and mid phalangeal fractures is corrected when the hand in position of function has relaxation of the wrist extensor tendons and of the long finger flexors. The dorsi-extended wrist and flexed finger joints (position of function) accomplished this. Stabilization on a volar splint for one or two digits integrated into a

hand-forearm cast permits free active use of uninjured digits. In multiple digit injury, especially with additional compound wounds, a position of function splint may serve better. A banjo splint is never indicated. A tongue blade finger splint causes complication of malalignment and extension contracture of joints.

The Bennett's fracture is treated by skeletal fixation through the head of the proximal phalanx of the thumb.

The boxer's fracture through the neck of the metacarpal, by right angle flexion of the proximal phalanx on the metacarpal and maintenance in a posterior slab plaster to hand and forearm exerting a backwards gentle pressure on the proximal phalanx. This holds the metacarpal head in position, stabilized by its joint ligaments.

The ruptured extensor tendon and/or fracture of the distal joint (baseball injury) is reduced and maintained with the distal joint in hyperextension and the mid joint of the digit in flexion, thereby securing greatest relaxation to the extensor tendon apparatus at the distal joint. Five to six weeks for union here is necessary.

Tendons are approximated with fine nonabsorbable suture (silk, nylon, stainless steel wire), 5-0 silk or nylon, No. 35 stainless steel wire. Maintenance of approximation depends not on the strength of suture but on relaxation gained by splinting—the wrist and proximal joints in flexion for flexor tendon repair, vice versa for extensor tendon. Tendons are relatively avascular and particularly susceptible to infection and indurated healing. In the narrow tendon sheath channels within the finger adherence is all too common. "No man's land" lies from the distal crease of the palm distally to the mid flexion crease. Primary tendon suture here seldom succeeds even when sublimis tendon is removed. It is invariably unsuccessful when both tendons are united within the sheath. Good results accrue from secondary repair after induration of injury has subsided (3-5 weeks). Far better to gain primary healing and accomplish secondary repair than to jeopardize eventual function through complicated indurated healing. Flexor tendons distal and proximal to "no man's land" give good results when repaired within 4-6 hours following a lacerated wound without crush. Crush is a contraindication to tendon repair. Subsidence of induration and secondary repair is the plan here. Extensor tendons which do not retract in sheaths are easily repaired.

Nerves are advantageously united even after the safe time interval for tendon repair has passed. Where crush is not a factor, primary neurorrhaphy with 6-0 eye suture and atraumatic needle of perineural, interrupted sutures will give good results. In crush or grossly contaminated wound, temporary union only may be indicated. Secondary repair (neuroplasty-lysis, removal of neuroma, and neurorrhaphy) is done following subsidence of induration.

The primary aim of early definitive hand care is uncomplicated healing.

All other aspects take secondary place.

IV. RECONSTRUCTION

Following healing of hand injury, residual damage frequently can be corrected or improved. If adequate circulation and freedom from fibrosis exist, reconstruction is usually warranted. Amputation is indicated only when the affected part cannot be restored to a useful level.

Reconstructive plastic surgery should be preceded by careful analysis of all structures damaged, by corrective dynamic splinting to mobilize stiff joints, and by active physio-occupational therapy to improve circulation and render the tissues supple. It is especially necessary to recognize all of the tissues damaged. Seldom is ununited or malunited fracture unaccompanied by soft tissue fibrosis, injured nerve or tendon.

With the reconstruction plan in mind and with tissues in optimum nutrition, surgery can be undertaken. If there has been infection, soft tissue can be corrected 3 months after wounds are closed; 6 months for bone repair. If there has been no infection, then the induration of injury may subside within 3-5 weeks. Reconstruction can then be carried out.

If damage is limited to surface covering, heavy split thickness skin grafts alone can remove constricting "gloves" of scar and allow full motion of fingers and limbering of restricted joints.

If deep structures require repair, sufficient padded soft tissue covering is necessary. This is obtained by bringing into the area a skin-fat pedicle. Local shift of tissue (Z-plasty, rotation flaps) may give sufficient coverage. If a greater area of tissue is lacking, pedicle skin is brought from a distance. Tube pedicles or broad based pedicle flaps are used. The constricting scar is removed (both surface and deep). The pedicle is sutured into place. After 3-5 weeks sufficient circulation will have developed from

the hand to the pedicle attached thereto. The pedicle base is then severed.

All deep repair (bone, nerves, joint, and tendon) must have proper coverage, either through uninjured skin or by replacement pedicle skin.

In general nerves are repaired as soon as possible, often times before bony repair. Nerve is freed from scar. Neuroma and scar ends are removed. The nerve ends are united without rotation, using 6-0 interrupted sutures through the neurilemma sheath. Nerve grafts of small calibre successfully bridge irreducible gaps.

Bony loss of deformity can be corrected by tibial graft of the long bones of the arm, and by ulnar, rib, or iliac grafts for the hand bones. Of these the iliac bone is the most suitable. Being cancellous, firm union occurs in 6-8 weeks. The graft is held in place with Kirschner wires. Motion at the joints is started before bony union occurs. Kirschner wires are removed after bony union is obtained, 6-8 weeks after operation.

Occasionally multiple tissues can be repaired at one time. For example, removal of surface scar, repair of tendon and nerves and tendon grafting or

occasionally bony repair may be carried out and immediate coverage by a pedicle of skin rotated into place.

In badly deformed hands, prostheses are second in choice to any reconstruction of remaining digits. One working finger with sensation is better than any leather and steel false hand.

Often sufficient digital portions remain so that pinch, hook, grasp can be given to the patient by activating these digits. Skin grafts may release scar. Tendon transfers afford motion. Nerve sutures return sensation. As the number of digits lost is increased the need for conserving and reconstructing the remainder becomes more essential. Phalangization procedures may permit the patient to return to useful work with his hand, perhaps in a trade denied to him were he to have a prosthetic arm.

In general, the golden opportunity for saving an injured hand is at the time of first treatment. Primary healing conserves tissue and prevents added deformity. Residual defects can be corrected by replacement of skin, nerves, tendons, and bones. This most important part of the body merits correction to reduce disability and economic loss.

METASTATIC CARCINOMA OF PENIS

Primary Lesion in Rectum

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THERE has been a great deal of interest of late in metastatic carcinoma of the penis. In the June, 1954 issue of the *Journal of Urology*, Wilson, Horton and Horton¹ stated that they were reporting the 32nd case of secondary carcinoma of the penis and the sixth arising from the prostate. The following primary sites had been reported:

	CASES
Bladder	7
Rectum	7
Prostate	6
Kidney	4
Lung	3
Testicle	3
Liver	1
Nasopharynx	1

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SUMMARY

A case of adenocarcinoma of the rectosigmoid with metastases to the penis is reported, this being the tenth case recorded in the literature as far as we have been able to determine.

At the June, 1954 meeting of the American Urological Association, Hamm and Weinberg² stated that secondary carcinomatous invasion of the corpora cavernosa had been reported in 34 instances. They presented three additional case reports, with primary sites in rectum, testis, and bladder.

The following cases have been reported with the primary lesion in the rectum: (Cases 1 to 6 summarized by Boyd³ in 1954).

1. 1933 Niewich
2. 1935 Mathesan
3. 1937 Stein and Hantsch
4. 1950 Thompson
5. 1951 Cattell and Mace
6. 1952 Bowersox and Frerichs
7. 1952 Ney⁴
8. 1954 Boyd³
9. 1954 Hamm and Weinberg²

The present case, therefore, would appear to be the 10th case reported of metastatic carcinoma of the penis with primary lesion in the rectosigmoid. This condition may be more prevalent because there undoubtedly are unreported cases.

At least six of the ten cases presented the complaint of priapism. Therefore all patients with priapism should have metastatic disease ruled out. The priapism is thought to be due to a blockage of the cavernous spaces of the corpora cavernosa by tumor tissue and engorgement of the remaining spaces with blood.

It is postulated, based on the work of Batson,⁵ that the method of spread is probably via the vertebral veins. Bowersox and Frerichs⁶ in an interesting discussion and review of the literature came to that conclusion, which seems reasonable to us, rather than via lymphatic spread into the perineal region via the inferior hemorrhoidal lymphatics as suggested by Boyd,³ because in the case herein reported there was no neoplasm in the perineum as shown by autopsy.

CASE REPORT

The patient was a 72 year old, white male admitted to McCook Memorial Hospital on October 19, 1953 for burning on urination, priapism, and difficulty in voiding of about five weeks' duration.

The past history was significant in that he had had an abdominoperineal resection for adenocarcinoma of the rectosigmoid 18 months prior to this admission. At that time he had local lymph node extension. Postoperatively he had done rather well, being followed in the Tumor Clinic regularly. Several polypoid growths on the mucosa of the colostomy were removed for biopsy in May 1953, five

months prior to the present admission, and these showed only "intestinal mucosa."

Present Admission: He was admitted on the Surgical Service which had been following him in the Clinic. Urological consultation was requested because of his urinary difficulties.

Physical examination showed an elderly male who appeared to be well developed and nourished. Vital signs were all normal. There was a well functioning colostomy. Priapism was noted to be present and there was bilateral lymphedema of the legs with chronic skin changes.

On admission, residual urine was 210 cc. The patient went into acute retention four days after admission, and it was then that urological consultation was requested. This showed priapism with extensive infiltration of both corpora cavernosa which were hard and nodular. The corpus spongiosum felt normal around the indwelling Foley catheter.

The urinalysis, NPN, CBC, acid and alkaline phosphatase, proteins and chlorides were all normal on admission.

Because he did not tolerate the catheter well, a suprapubic cystostomy with circumcision of tight foreskin, as well as biopsy of the hard infiltrated area in the penis were done 8 days after admission. Pathological examination showed metastatic adenocarcinoma of the corpora cavernosa appearing identical to the original rectal cancer (Figures 1 and 2).

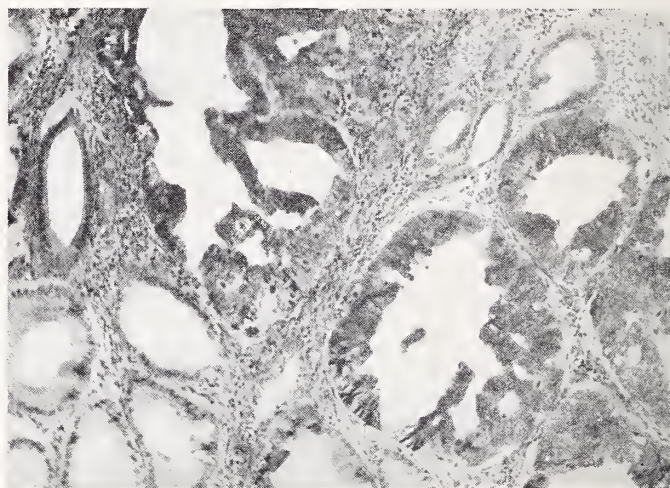


FIGURE 1

The primary carcinoma in rectum

The patient tolerated the suprapubic cystostomy well, but complained bitterly of penile pain on account of the priapism. Accordingly on November 13, 1953 the penis was amputated down to where the corpora cavernosa was attached to the pubic arch. The urethra was freed and brought out as a perineal urethrostomy. Although both corpora cavernosa were extensively infiltrated with neoplasm, the urethra and corpus spongiosum were free of tumor. (Operation by Thomas M. Feeney, M.D.).

The pathological examination (Perry Hough, M.D.) showed that both corpora cavernosa were entirely replaced by an adenocarcinoma appearing identical to the original carcinoma of the colon.

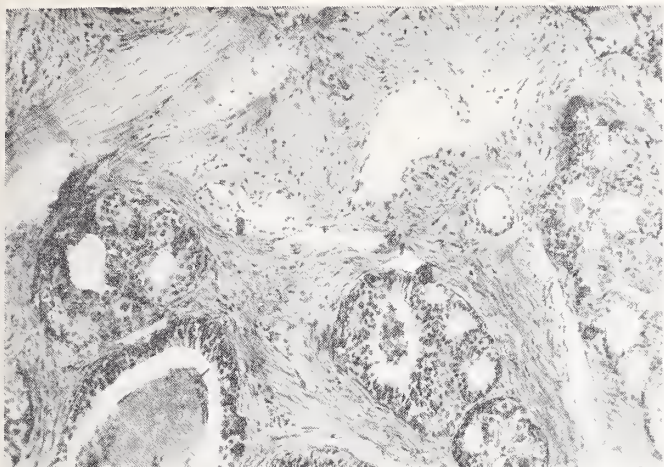


FIGURE 2

The metastatic carcinoma in penis (Corpora Cavernosa)

Following the penile amputation the patient had intermittent difficulty in voiding through the urethrostomy, although the amputation was successful in that it relieved him of the penile pain and priapism. The cystostomy was allowed to close.

On December 22, 1953, 39 days after the amputation and urethrostomy, the perineal urethral meatus was located with difficulty, due to indurated tissue in the perineum, probably metastatic carcinoma. (This was an erroneous impression as shown by the autopsy findings, *vide infra*).

The perineal meatus was finally located and the urethra was dilated and a Foley catheter left in the bladder.

He was also troubled at this time with pains in his legs and x-rays showed multiple metastatic bony changes in the lower extremities. A biopsy was planned but the patient refused.

On December 28, 1953, two months and nine days after admission, the patient was discharged from the hospital and placed in the male infirmary, with the Foley catheter in situ via the perineal urethrostomy. The Foley catheter was re-

moved on February 4, 1954 and the patient voided satisfactorily.

His condition deteriorated and he died on February 16, 1954. Postmortem examination was obtained.

POSTMORTEM EXAMINATION (PERRY HOUGH, M.D.)

Positive findings included metastatic colonic adenocarcinoma of the bones of the right foot and ankle, and multiple metastatic nodules in the lungs bilaterally. Relevant negative findings: There was no evidence of neoplasm at the site of the penile amputation or perineal urethrostomy. The liver, spleen, kidneys, adrenals and abdominal lymph nodes were free of metastatic disease.

CONCLUSION

Any patient with priapism should be investigated for malignant disease of the penis, either primary or secondary.

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RATIONALE OF THE DIAGNOSIS AND TREATMENT OF ADDICTIONS

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SUMMARY

From the standpoint of the clinical problem involved, drug addiction is defined as "pharmacological dependence" (both "psychic" and "physical"), and its diagnosis is based on the demonstration of an abstinence syndrome. Currently, opiates, barbiturates and alcohol are the most commonly used "addicting" drugs. Other agents, like cocaine, amphetamine and marihuana may produce dangerous toxic effects when used in excessive amounts, but the clinical problem involved differs from that of addiction, since abrupt withdrawal of such agents produces neither intensified "craving" nor distressing physical disturbances. Treatment of drug addiction may be divided into two phases: withdrawal of drugs and rehabilitation. Withdrawal of opiates can be accomplished most readily by the substitution of methadone by the oral route, and rapid reduction of methadone dosage over a period of

seven to ten days following a short period of "stabilization." Barbiturates should be withdrawn by gradual reduction, over a period of three weeks or more, following a short period of stabilization on pentobarbital. The problem of the management of alcohol withdrawal requires further investigation. The rehabilitation program includes confinement in a drug-free environment for four to six months, vocational training and occupational therapy, and formal psychotherapy when possible.

The rationale of the diagnosis and treatment of drug addiction is discussed from the standpoints both of empirical evidence and of theoretical formulations of the psychological and physiological mechanisms of addiction. Abstinence phenomena are viewed from the standpoint of the "counter-adaptation" theory, and attention is directed to the important role which, among other factors, previous pharmacological dependence may play in the genesis of subsequent relapse. Areas for future research, both of a psychological and a physiological nature, are indicated in relation to both the "nonpurposive" and "purposive" abstinence phenomena that characterize the clinical problem of drug addiction.

PROGRESS in any field of medicine is measured, not only in terms of the efficacy of methods available for the relief of human suffering, but also the degree to which treatment is based upon scientifically acceptable explanations of the genesis of particular illnesses. Viewed from both of these standpoints, considerable "progress" in the management of addictions appears to have been made in recent years, but many problems of major importance remain to be solved. It is the purpose of this discussion to indicate the extent of our present knowledge in relation

to currently used methods of diagnosis and treatment of opiate and barbiturate addictions. Although some allusions will be made to alcoholism, this problem will be considered only to the extent that it has been investigated at the Lexington hospital.

DEFINITION OF ADDICTION

The United Nations Expert Committee on Drugs Liable to Produce Addiction has defined drug addiction as follows: "Drug addiction is a state of periodic or chronic intoxication detrimental to the individual

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and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: (1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; (2) a tendency to increase the dose; (3) a psychic (psychologic) and sometimes a physical dependence on the effects of the drug." Undoubtedly this definition is very useful for the purpose of facilitating international control of traffic in potentially harmful drugs. However, for the needs of the practicing physician, "drug addiction" should be defined in terms of the problem with which he is called upon to deal. In general, the problem involved is the management of persons who display pronounced disturbances in behavior when they are deprived of certain drugs which are considered to be harmful to the individual, society or both. In this sense, "drug addiction" is synonymous with "pharmacological dependence," and is said to exist when abrupt and complete withdrawal of certain agents is followed by an "abstinence syndrome," which may consist only of "craving" and persistent seeking out of drugs, or these "purposive" abstinence phenomena may be associated with more transitory "nonpurposive" changes involving the neuromuscular, autonomic and endocrine systems. Both "purposive" and "nonpurposive" abstinence phenomena are associated with the regular, continuous use of opiates, barbiturates or alcohol. The abuse of other agents, such as amphetamine, marihuana or cocaine constitutes a distinctly different problem in medical management. In sufficiently large amounts, these agents can produce dangerous effects, from which both the user and society may suffer. However, sudden withdrawal of such drugs produces few or no "nonpurposive" abstinence changes, while "purposive" abstinence phenomena are rarely as insistent or difficult to cope with as in the case of opiates, barbiturates or alcohol. As will be indicated later, it is probably more than a coincidence that of all the so-called "euphoriant" agents that are available, those are "craved" most by addicts which, after regular continuous use, produce "nonpurposive" abstinence phenomena.

DIAGNOSIS OF ADDICTION

In accordance with this definition, the diagnosis of drug addiction involves the demonstration of an abstinence syndrome. Because they are more easily measured, and are less subject to the influence of uncontrollable factors, the "nonpurposive" abstinence phenomena are used as the basis for diagnosis.

Their demonstration, however, should be carried out only in a hospital by a physician specially trained in the recognition of the specific abstinence syndromes that characterize opiate, barbiturate and alcohol addictions. These are quite distinctive, and will therefore be discussed separately.

THE OPIATE ABSTINENCE SYNDROME

Following abrupt and complete withdrawal of morphine, heroin, dilaudid, codeine, methadone, meperidine or a number of other morphine derivatives and potent synthetic analgesics, a train of symptoms and signs ensues which conforms to a general pattern, though differences in time, course and intensity of particular disturbances characterize addictions to individual drugs of the opiate-like class. In the case of morphine, the fully developed abstinence syndrome consists of the following train of events: yawning, lacrimation, mydriasis, rhinorrhea, perspiration, chilly sensations, piloerection (arms, forearms, axillary regions, abdomen), muscular aching, muscle twitches (especially in the legs), nausea, vomiting, diarrhea, restlessness, anxiety, tachypnea, hypertension, anorexia, insomnia, weight loss, ejaculations in men and orgasms in women. Significant laboratory findings include leukocytosis, pronounced drop in counts of circulating eosinophiles, and increased urinary excretion of 17-ketosteroids. Such changes can be detected as early as the 14-20th hour, reach peak intensity between the 48-72nd hour of abstinence, and subside rapidly during the next five to ten days. However, minimal abstinence changes may persist for as long as six months. At any time during the acute abstinence period, a single dose of morphine (e.g., 30 mg.) produces a prompt and pronounced reduction of the intensity of all of the disturbances listed, which lasts six to twelve hours, after which the intensity of the abstinence syndrome returns to the value that it would have reached at that time if untreated. This phenomenon may be utilized as confirmatory evidence that the disturbances are indeed morphine abstinence changes. The over-all intensity of the morphine abstinence syndrome varies individually, but is remarkably reproducible in any given subject under controlled experimental conditions, and varies within limits with the dosage and duration of morphine addiction.

The heroin and dilaudid abstinence syndromes resemble that of morphine except that withdrawal phenomena appear and reach peak intensity sooner, and they subside more rapidly. That of codeine is

milder, while the methadone abstinence phenomena, while mild, are more persistent than in the case of morphine. Addiction to meperidine, however, presents unique problems. Abstinence phenomena (yawning, lacrimation, rhinorrhea, perspiration, isolated muscle twitches and extreme restlessness) may appear within two hours after the last dose, and impel the user to increase the frequency as well as the amounts of meperidine injected. When a daily dose level of approximately 3,000 mg. has been reached, direct toxic effects of the drug, in the form of myoclonic jerks and/or generalized convulsions may be superimposed on the abstinence phenomena.

Very recently a more rapid method of precipitating abstinence syndromes in cases of addiction to morphine, heroin, methadone and a number of other opiate-like drugs, except meperidine, has been developed. This utilizes the remarkable opiate-antagonistic properties of N-allylnormorphine ("nalorphine," U.S.P.; "Nalline," Merck). In nonaddicted, previously nonmedicated individuals, 5-15 mg. of this compound produces effects that are quite similar to smaller doses of morphine, including depression of respirations. In nonaddicted persons who have received "therapeutic" doses of morphine, N-allylnormorphine, in the doses mentioned, antagonizes many of the morphine effects (particularly "euphoria"), but not the depression of respirations. In nonaddicted individuals whose respirations and arousability have been seriously depressed by larger doses of opiates, relatively small doses of N-allylnormorphine produce a spectacular, though transient restoration of respiratory rate and depth to normal or supernormal values, and facilitate arousal. In opiate addicts (with the exception of those addicted to meperidine), however, N-allylnormorphine precipitates well defined abstinence syndromes of short duration (1-2 hours) within 15 minutes after subcutaneous injection, even when the addicted individual has been rendered comatose and almost apneic by an overdose of an opiate-like drug. The intensity of such N-allylnormorphine-precipitated abstinence syndromes varies directly with the intensity of addiction and the amount of N-allylnormorphine administered. If the latter is excessive, dangerously intense "withdrawal" phenomena may ensue. For the diagnosis of addiction the initial dose of N-allylnormorphine should not exceed 3 mg. If yawning, lacrimation, mydriasis, rhinorrhea, perspiration and/or piloerection do not appear within 15 minutes after subcutaneous injection, an additional dose of 5

mg. may be administered by the same route. If such abstinence phenomena fail again to make their appearance, a final dose of 7 mg. (15 mg. total) may be given in a similar manner. A positive result indicates that the subject has been using an opiate-like drug in sufficient amounts, and with sufficient regularity to have developed pharmacological dependence. This has been demonstrated to occur in former opiate addicts who have received as little as 15 mg. of morphine, 15 mg. of heroin or 10 mg. of methadone four times daily for as short a period as two or three days. A negative result indicates either that the subject has not developed pharmacological dependence, or that he has been abstinent for as little as perhaps one week, since it has been shown that immediately after subsidence of an opiate abstinence syndrome, N-allylnormorphine exerts effects identical with those in nonaddicted, nonmedicated individuals.

The mechanisms of action of N-allylnormorphine have not yet been fully elucidated. However, a considerable body of evidence obtained in clinical studies, and in investigations on animals and animal preparations, justifies the following tentative explanation. Single doses of opiate-like drugs produce a mixture of "depressant" and "excitant" actions at all levels of the central nervous system, the pattern of which differs from that characterizing the effects of other drugs with somewhat similar actions, like barbiturates and mephensin. The depressant effects of single doses of opiate-like drugs are often followed by secondary "rebound" changes in the same functions, with consequent enhancement of activity. When multiple, fixed doses of opiate-like drugs are administered daily for variable periods of time, the initial depressant effects become progressively less noticeable, while the "rebound" enhancement of functional activity becomes intensified. In part, such "tolerance" may be ascribed to the development of hypothetical cellular "counter-adaptations" in the central nervous system which can be held in check only by additional opiates, the dose of which must be increased progressively up to a limiting value in order to prevent the appearance of an "abstinence syndrome." It is further hypothesized that the N-allylnormorphine molecule "competes" with molecules of opiate-like drugs for the cellular receptors of the central nervous system, that they enter the cell more rapidly, have a greater "affinity" for the receptor sites, and that they do not "mask" the counter-adaptations. Consequently, N-allylnormor-

phine can not only antagonize the depressant actions of opiate-like drugs, but it can also "unmask" the counter-adaptations which are responsible for the abstinence syndrome. At present, the concepts "counter-adaptation," "molecular competition" and "affinity" are not phenomena that can be measured independently of those that they purport to explain. However, they appear to be useful postulates, since they have served to facilitate the prediction of many observable effects of single and repeated doses of various drugs.

THE BARBITURATE ABSTINENCE SYNDROME

Following abrupt and complete withdrawal of short-acting barbiturates, such as secobarbital, pentobarbital or amobarbital, a series of phenomena develops, the intensity of which is related directly to the degree, continuity, and duration of drug intoxication, with the usual individual variations. In persons who have received 1.0 Gm. or more of such barbiturates daily for six weeks or longer, tremulousness, weakness, postural hypotension and syncope, anxiety, anorexia and insomnia appear regularly by the end of the first day of abstinence. In addition to these phenomena, one to four generalized convulsions may be expected in approximately 80 per cent of such individuals on the second or third day, in association with pronounced abnormalities, often of the paroxysmal "spike and dome" variety in the electroencephalogram. In roughly 60 per cent, psychoses, most often indistinguishable from alcoholic delirium tremens, can be expected to occur between the fourth and seventh days, with spontaneous recovery within a week thereafter. Replacement on barbiturates serves to suppress all of the abstinence phenomena, except the psychoses which, once well under way, tend to run their course, although occasionally rapid recovery occurs after prolonged sleep has been induced by anesthetic doses of a barbiturate. It has also been established experimentally that in subjects who have received 0.6-0.8 Gm. of short-acting barbiturates daily for similar periods, only anxiety, tremulousness, postural faintness, anorexia, insomnia and weight loss are likely to appear on abrupt withdrawal of the agents concerned. In about 10 per cent of those taking 0.6 to 0.8 Gm. daily, convulsions may develop, and a similar incidence of mild, transitory psychotic episodes has been observed. Data are not yet available to enable the prediction of the nature and intensity of abstinence phenomena, if any, that can be expected to occur in individuals taking less than

0.6 Gm. daily. In general, however, it appears that the intensity of abstinence phenomena is related directly to the degree and duration of chronic intoxication that existed before withdrawal.

At present, little is known concerning the mechanisms that are involved in the genesis of the barbiturate abstinence syndrome. The fact that convulsions occur after withdrawal of drugs with anti-convulsant properties, suggests again that "counter-adaptations" may develop at cortical or subcortical cellular levels during chronic barbiturate intoxication. On the other hand, alternative hypotheses can be advanced, based upon recent evidence that barbiturates exert selective depressant actions on the brainstem reticular activating system, and the role of this and the diffuse thalamic projection system in the genesis of seizures. Unfortunately, practically no studies have been made on the neurophysiological changes that occur during recovery from the initial depressant effects of barbiturates. Carrying out of such investigations would entail technical difficulties of formidable proportions, but they appear to be necessary for the ultimate resolution of the problem.

THE ALCOHOL ABSTINENCE SYNDROME

Very recent experimental studies support strongly the view that "rum fits" and delirium tremens, currently regarded by many as toxic effects of alcohol, are, in fact, alcohol abstinence phenomena. In addition, this syndrome includes other well known but less dramatic changes such as tremulousness, nausea, perspiration, insomnia, vomiting, diarrhea, hyperreflexia, fever, hypertension and transient visual and auditory hallucinations. These may occur several hours after the last previous drink during chronic alcoholic intoxication, but they are suppressed temporarily by another drink. If, on the other hand, alcohol is withheld, and other "sedative" drugs are not administered, they increase in intensity over a period varying from one to several days. Thereafter they may subside, or classical delirium tremens may supervene, with or without antecedent seizures. The intensity of the alcohol abstinence syndrome appears to be related directly to the degree and duration of continuous alcoholic intoxication prior to abrupt withdrawal. Sufficient data are not yet available to enable one to quantify this relationship, but in a group of six former opiate addicts who received up to 489 cc. of 95 per cent alcohol daily for as long as 87 days, abrupt withdrawal of alcohol was followed by seizures in two cases, transient hallucinations in two, and classical delirium tremens in two

(possibly three) instances, while other abstinence phenomena could be demonstrated in nearly all of the subjects. In general, the alcohol and the barbiturate abstinence syndromes are very similar, but some differences are notable. Thus, demonstrable abstinence changes appear only after 14 hours or more following abrupt withdrawal of barbiturates, while alcohol withdrawal changes may appear between drinks during chronic alcoholic intoxication, and increase in intensity progressively when alcohol is withheld. Seizures appear to occur more commonly, and paroxysmal abnormalities in the electroencephalogram are far more prominent and persistent after abrupt withdrawal of barbiturates than in the alcohol abstinence syndromes. Also, psychoses become manifest only after a lucid period of four to seven days following abrupt withdrawal of barbiturates, while a continuum of transient hallucinosis with clear sensorium changing imperceptibly to the confusional, disoriented, agitated, delusional and hallucinatory state characteristic of delirium tremens may begin within a few hours after the last drink of alcohol.

As in the case of the barbiturate abstinence syndrome, little is known of the mechanisms that contribute to the genesis of the alcohol withdrawal phenomena. Because of the striking similarities of the two syndromes, it may be anticipated that similar mechanisms operate, and that further research of the sort indicated above is needed.

TREATMENT OF ADDICTION

In this section, discussion of treatment will be limited to that of opiate and barbiturate addiction, since active addiction to alcohol is rarely encountered among patients admitted to the Lexington hospital, and studies on the treatment of experimental alcohol addiction have not yet been made at this institution.

Treatment of opiate and barbiturate addiction should be carried out only in an institution specially designed for this purpose. Facilities should include not only the usual medical and surgical services, but also an adequate psychiatric "team," consisting of psychiatrists, psychologists and social service workers. Opportunities for vocational training, realistic occupational therapy and recreation should be available, and rigorous exclusion of contraband drugs should be possible. Immediately on admission, the patient should receive a careful physical and at least a preliminary psychiatric examination. In obtaining

the history, special attention should be given to the type, amounts and frequency of drug intake. Ideally opiates and/or barbiturates should be administered for a few days in amounts just sufficient to prevent the appearance of abstinence phenomena. During this "stabilization" period, the necessary examinations can be made, and systematic therapy planned. The latter can be divided into two phases: first, withdrawal of drugs, and second, rehabilitation. Psychotherapy is utilized in both phases, but with different emphasis and will therefore be discussed separately in connection with drug withdrawal and rehabilitation.

WITHDRAWAL OF OPIATES

Before the introduction of methadone, this phase of treatment was managed most successfully by the method of "rapid reduction." In brief, this consists of subcutaneous injections of successively diminishing doses of morphine, or whatever opiate-like drug had been used in stabilization, in amounts and with frequencies of injections calculated to complete withdrawal within five to ten days without inducing excessive vomiting, diarrhea, tachycardia or fever. However, this method demands much of the time of physicians and attendants, and may prove to be rather stormy if the intensity of pharmacological dependence has been estimated inaccurately. A much simpler method consists of the substitution of methadone for the drug used in "stabilization," and subsequent withdrawal of this synthetic analgesic by rapid reduction. Formerly, methadone was administered subcutaneously in a dose ratio of approximately 1 mg. of methadone for 3 mg. of morphine or in equivalent ratios for other opiate-like drugs. With subcutaneous injections, substitution was begun by "overlapping" successively diminishing doses of the "stabilization" drug with methadone in the course of one day, in order to prevent the appearance of severe abstinence phenomena during the transition period. "Stabilization" on methadone was then continued for five to seven days, after which the drug was withdrawn in steps over a period of three to four days. Recently, however, the methadone substitution method has been simplified even further, by administering the drug orally in approximately the same ratios described above. In the case of the average opiate addict admitted to the Lexington hospital, no "overlapping" appears to be necessary, and the daily amount of methadone needed for "stabilization" can be administered in two divided doses. Rapid reduc-

tion of methadone can be begun after two days of "stabilization," and completed in seven to ten days. However, in patients with active pulmonary tuberculosis or myocardial disease, withdrawal of methadone should be carried out with special caution, over a period of perhaps a month or more.

The methadone substitution method offers many advantages over the "rapid reduction" technic. The clinical course is apt to be less stormy, and, as noted above, the methadone abstinence phenomena are much less intense than those of morphine. Furthermore, the feasibility of administering methadone orally obviates the necessity for sterilization of needles and syringes as well as the administration of multiple daily injections, and hastens the "weaning" of the patient away from whatever symbolic significance injections may have. On the other hand, special care must be exercised to guard against cumulative depressant effects of methadone, which are greater than those of morphine, and although the patient's complaints are fewer during the withdrawal period, they persist longer than after withdrawal has been accomplished by the "rapid reduction" method.

WITHDRAWAL OF BARBITURATES

At present only a "gradual withdrawal" method has been found useful in the treatment of barbiturate addiction. As in the case of opiate addiction, this should be preceded by a "stabilization" period of several days' duration, during which adequate amounts of a barbiturate are administered to suppress all abstinence phenomena, and induce a state of mild intoxication. Also as in opiate addictions it has been found that various barbiturates can substitute for one another, and, in practice, pentobarbital appears to be the drug of choice for "stabilization," since its duration of action is such that four oral doses daily in the proper amounts can prevent the appearance of abstinence phenomena, without producing more than a mild degree of intoxication. However, abrupt withdrawal of any of the relatively short-acting barbiturates (secobarbital, pentobarbital or amobarbital) may be followed by the dangerous abstinence phenomena described above. Consequently, withdrawal of pentobarbital must be carried out with caution. In the average case this can be accomplished by reducing the "stabilization" daily dose of barbiturates by 0.1 or 0.2 Gm. each day, with close observation for early abstinence changes such as tremulousness, weakness and postural hypotension. If these supervene, further reduction should be suspended. Generally they will

disappear in a day or two, when the reduction schedule may be resumed. As a precautionary measure the patient should rest on a mattress laid on the floor, lest injuries be sustained if convulsions occur. Because of the danger of psychotic disturbances, the patient should be observed at all times by attendants and physicians trained to recognize early manifestations. Since fully developed barbiturate withdrawal psychoses are not readily reversed, it is better to err on the side of excessively slow reduction than the opposite. In severely addicted individuals a month or more may be required for complete withdrawal of barbiturates.

If barbiturate and opiate addiction coexist, as is not infrequently the case, withdrawal of opiates should be accomplished first, while the patient is stabilized on barbiturates. Curiously many patients who tolerated a given daily stabilization dose of barbiturates well previously will exhibit more evidence of barbiturate intoxication after opiates have been withdrawn. In such cases the "stabilization" dose may be reduced somewhat before systematic withdrawal is initiated.

PSYCHOTHERAPY

During this phase of therapy the physician should orient his activities toward the primary object at hand, namely, withdrawal of drugs. His role should be sympathetic but firm, and discussion of problems likely to arouse intense emotional reaction should be avoided. On the other hand, he should be alert to the development of severe depressive reactions because of the danger of suicide, especially immediately after all drugs have been withdrawn. Fortunately such disasters have occurred very infrequently, but milder depressions of temporary duration are not uncommon. Physicians who are confident of their own skill in the management of drug withdrawal generally have much less difficulty with patients who are quick to "size up" the therapist and to seize control of the situation, if indecision, anxiety or hostility are displayed toward them.

The rationale of the methods described can be considered from several points of view. In some areas the "cold turkey" method of abrupt withdrawal is still used, on the assumption that suffering will act as a deterrent. That this is not the case is indicated by the frequent relapses of addicts who have undergone such "treatment" in various institutions, principally penal ones. Furthermore, there is reasonable inferential evidence that such suffering may actually allay any feelings of guilt that are present,

thus justifying relapse on the grounds that the addict "has paid his debt to society." Since, in any case, measurement of relapse rate has been exceedingly difficult, if not impossible to accomplish, the more humane methods outlined can be more readily justified. Of these, the "rapid reduction" method is based on the empirical observation that the total duration of the opiate abstinence syndrome is not prolonged by successively reduced "braking" doses of opiates. The methadone substitution method is based on the repeatedly observed fact that when drug A is substituted for drug B, the agent on which the addict has been stabilized, and A reproduces the state maintained by regular use of B, abrupt withdrawal of A is followed by the same abstinence syndrome that would have occurred if the stabilizing drug had been A. Both of these empirical facts are consistent with the "counter-adaptation" explanation of drug addiction which was discussed earlier. While this postulate is inferred from abundant evidence of a physiological nature, there is clinical evidence that psychological mechanisms also contribute to the genesis of even the "nonpurposive" abstinence phenomena. As yet these have not been investigated experimentally in a controlled manner, but theoretical considerations indicate that psychotherapy may be very useful in the drug-withdrawal phase of treatment, if properly applied.

REHABILITATION

This phase of the treatment of drug addiction is designed to prevent relapse, or at least to reduce its incidence. As currently practiced at the Lexington hospital, rehabilitation includes controlled abstention from drugs, correction of medical and surgical disorders, vocational training, recreational activity and psychotherapy. Unfortunately, a reliable method for measuring relapse rate after discharge from the institution has been very difficult to devise, and at present it is not possible to evaluate the comparative efficacy of this, versus other possible programs, on an empirical basis. Therefore, the rationale of such treatment can be discussed only in terms of the assumptions and hypotheses upon which it is based.

Perhaps the most generally applicable statement that can be made is that by the continuous use of certain drugs, the addict has developed a "modus vivendi" which is of value to him, however undesirable it may be from the standpoint of others. Consequently, re-education in a drug-free environment appears to be essential if the probability of

relapse is to be reduced. However, no "controlled" environment can duplicate the everyday life situations to which the patient must return. Hence the period of confinement in an institution should be limited ideally to that which affords sufficient time for available methods of re-education to be given a thorough trial. This will vary from patient to patient, but currently, a period of four to six months is considered sufficient. In re-education, vocational training assumes a very important role, since many addicts have never acquired socially useful skills which could serve as a basis for self support, or for sources of satisfaction and preservation of self esteem. Likewise, the desirability of recreational activity and improvement in general health requires little justification.

The problem of psychotherapy is much more complicated. What the psychotherapist does, says, looks for, finds, misses, emphasizes or ignores depends to a great extent on the body of concepts concerning behavior which he accepts as valid and relevant to the problem at hand, and these, in turn, determine to a considerable degree the responses elicited from the patient. Yet validation of such concepts by the scientific test of predictive utility has proved to be a difficult task in all areas of interest to psychiatrists, including that of drug addiction. Hence, it is not surprising that psychiatrists differ widely in their views concerning the psychodynamics of drug addiction and the particular problems which should be explored in formal psychotherapy.

Perhaps the most prevalent view is that drug addiction is not a "disease" but a symptom of an underlying personality defect. Because of their "anxieties," such persons are attracted to drugs which produce "euphoria." Pharmacological dependence tends to perpetuate drug use because of the patient's fear of withdrawal discomfort, but otherwise it is unimportant. Relapse after a period of abstention is due again to the underlying personality defects, the correction of which is the object of psychotherapy. These defects have been variously described. From a symptomatological standpoint the majority of addicts at the Lexington hospital have been classified as "psychopathic" or "neurotic," or in equivalent terms consistently over a period of almost 20 years. A very recent study, using the Minnesota Multiphasic Personality Inventory, has yielded similar results, with more emphasis on "psychopathy." In dynamic terms these patients

have been characterized as narcissistic, oral-dependent and passive-aggressive. It is further assumed that these defects antecede, and are etiologically related to drug addiction.

However, this formulation fails to account for the facts that only a small proportion of persons with such defects are drug addicts, that addicts exhibit very strong preferences for one or another drug, and that major addiction problems arise, at least in the United States, mainly in relation to drugs which produce "nonpurposive" as well as "purposive" abstinence phenomena. What appear to have been ignored in the formulation summarized above are the pharmacological factors—the facts that because of the nature of their associations and contacts, "psychopathic" and "neurotic" individuals are more apt to become acquainted with drug effects, that these are quite specific for particular drugs, and that the regular use of one or another may alter the users' goals in life, as well as satisfy previously existing needs.

In other words, drug addiction, as defined in the introduction of this paper, must be viewed as a consequence of experience with drugs in a setting that endows such experiences with important values to the user, of which he may or not be aware. Furthermore, the most enduring experiences are not the fleeting effects of the first few "trial" doses (which may or may not be "pleasant"), but the long maintained state of pharmacological dependence. Contrary to the "conscious" interpretations of most addicts, there is much inferential evidence that "being hooked" serves many "unconscious" purposes, varying in kind and degree from one to another individual. In some, pharmacological dependence represents a continuous enactment of hostile behavior toward special figures or society in general. In others, it represents a process of gradual self destruction. But in many, this state fulfills a need which has generally been overlooked, but appears to be of prime importance to human beings—the need for continuous activity directed toward attainable, but recurring goals. The consequence of failure to satisfy this need is an intolerable state of boredom. This may be relieved temporarily by the use of any of a large number of drugs which alter affective behavior, but only those that produce pharmacological dependence can furnish a continually recurring "synthetic" need that can be readily satisfied. The activity necessary for assuring a continuous supply of drugs (termed "hustling" in the

addicts' jargon), provides a sense of accomplishment, much as the acquisition of money by law-abiding citizens, and serves to enhance the prestige of the "hustler" in the eyes of himself and fellow addicts. Under favorable circumstances, particularly if different goals for sustained activity are acquired by re-education, relapses to drug use may not occur. But since the manifestations of "natural" needs can become "conditioned," those of "synthetic" needs may also be activated in response to specific stimuli, and hence previous pharmacological dependence can become an important factor in the genesis of subsequent relapse.

However, while various types of pharmacological dependence are similar with regard to the recurrent cycle of acquired need and satisfaction thereof, they differ with respect to over-all changes in behavioral patterns that different drugs produce. At least in a controlled experimental situation, pronounced differences are observed between the behavior of persons actively addicted to opiates and others to barbiturates or alcohol. In amounts used by addicts, the latter two agents facilitate loss of restraint and aggressive "acting out" on slight provocation, whereas opiates generally produce an opposite state, characterized by passivity, rather than overt aggressiveness, and "detachment," rather than embroilment in the interpersonal aspects of the environment. "Primary" needs, such as sexual urges, hunger and fear of pain may be unaltered or enhanced by barbiturates or alcohol, but they are reduced in intensity by opiates. Both of these classes of drugs may be said to relieve "anxiety," but if so, the "anxieties" relieved are of different sorts. Likewise, the term "euphoria" has been applied to the states produced by these and many other drugs, but even the addict, untrained in semantics and in self observation, is quick to note that there are various kinds of "euphoria." Analyzed operationally, the term "euphoria" seems to denote little else than that in a particular setting, an individual "likes" certain drug effects very much. Who will "like" the effects of one class of drugs more than those of another, may very well be related to previously established preferences for particular patterns of behavior. The opiate addict, generally speaking, lacks aggressiveness and competitiveness, and prefers to handle "anxiety-producing" situations by withdrawing from, or circumventing them. Such individuals would therefore prefer opiates. On the other hand, since barbiturates, and particularly alcohol, facilitate "pseudo-masculine" behavior patterns, they

would be preferred by individuals with strong aggressive and competitive strivings. No doubt the hypothesis here advanced represents an over-simplification of the problem of specificity of drug preferences, but it may serve as a basis for future research.

At present little is known of the physiological mechanisms that contribute to the genesis of relapse. In large part this is due to the fact long enduring, drug-seeking behavior following termination of experimental addiction has not been reproduced experimentally in animals. Therefore, severe limitations are imposed on the extent to which the structure-function aspects of relapse can be investigated. It has been shown, however, that in man bilateral frontal lobotomy abolishes or reduces the intensity of "purposive" morphine abstinence phenomena, without altering the "nonpurposive" changes. How permanent this effect is cannot be estimated until reliable methods for measuring relapse rate are devised. In the light of our current knowledge it appears that this procedure should be employed only in the treatment of addicted patients with chronic, intractable pain after careful weighing of the consequences of continued addiction against the consequences of frontal lobotomy in each individual case. Electroconvulsive therapy has also been advocated for the treatment of drug addiction, but the

published evidence does not permit a critical evaluation of its efficacy, either with respect to the management of the drug-withdrawal phase of treatment, or the prevention of relapse. Present methods for drug withdrawal are quite satisfactory, and electroconvulsive therapy would seem to offer no particular advantages. However, the possibility of using this treatment in the prevention of relapse merits further investigation.

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PRACTICAL ASPECTS OF THE TREATMENT OF PULMONARY TUBERCULOSIS

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SUMMARY

1. In October, 1954 streptomycin-PAS may be the best regimen for pulmonary tuberculosis because it saves isoniazid to use with pyrizinamide in case pyrizinamide-isoniazid proves to be as good a regimen at it is beginning to look. It should be emphasized that this new regimen apparently does not work if either drug has been taken before without the other.

2. Streptomycin-isoniazid may be the poorest regi-

men because it commits our two best agents at once with results not quite as good as with isoniazid-PAS or streptomycin-PAS-isoniazid. If streptomycin-isoniazid is to be used, streptomycin should be given daily and not twice weekly.

3. The general tendency to avoid PAS is unwise.

4. The resection of closed lesions in patients no longer infectious during prolonged original chemotherapy has been proven quite safe but is it necessary?

5. Home treatment as a continuation of treatment started in the tuberculosis hospital is apparently satisfactory but treatment started at home or, even worse, at work, is asking for trouble in the future.

From Trudeau Sanatorium of the Trudeau-Saranac Institute, Trudeau, N. Y.

Presented at the New England Regional Meeting, American College of Physicians, Hartford, Connecticut, October 22, 1954

THE treatment of pulmonary tuberculosis may be divided essentially into five parts: chemotherapy, rest, collapse, resection and education.

Leading the list of current questions is the advisability of home or ambulant treatment. Home treatment, at least, has already been approved by private practitioners, a fact witnessed by the necessity of closing of Trudeau Sanatorium because of too few patients.

Four points should be made regarding the advisability of home or ambulant treatment.

1. On a mean distribution curve of tuberculosis patients, at one extreme there are those who will do well with no treatment; at the other extreme there are those who will not do well with maximal treatment; and there are all gradations in between. There is no test to enable us to distinguish the "sheep" from the "goats" at the outset. In addition, an initial satisfactory response to chemotherapy does not by any means ensure ultimate success. These basic facts, known to all of us who have treated tuberculosis, explain in part why some patients do well or appear to do well without rest, with short courses of chemotherapy or with treatment inadequate in some other way.

2. It is now known that success with chemotherapy in the average case depends on adequate duration and integration of collapse and resection at the proper time, and avoiding interruptions and changes in treatment.

3. Education regarding the relapsing and contagious nature of tuberculosis and the details of good chemotherapy is more effective in groups at a tuberculosis hospital than to individuals in the home environment.

4. We must realize that the favorable results of ambulant chemotherapy have come principally from Sunmount Veterans Administration Hospital and the National Jewish Hospital in Denver where the patients have been long term hospital residents under close observation and guidance and not at work. Furthermore, the one report to date on truly ambulant treatment from New York City included rates of cavity closure and sputum conversion which do not compare favorably with our experience at Trudeau Sanatorium.

On the other hand, home treatment, and even ambulant treatment, has a place after the successful initiation of well integrated treatment at the tuberculosis hospital.

A second practical problem today is the social standing of para-aminosalicylic acid (PAS). There is a great temptation not to use PAS because it is often difficult for the patient to take and difficult for the doctor to administer. Clinically it is now apparent that the side effects of PAS are more common in the aged and the clinically sick. There is also good evidence that aging of the drug increases the likelihood of these side effects. Hypersensitivity to PAS is to be distinguished from toxicity. It is characterized by high fever, skin rash, prostration and leucopenia; it may be handled in most cases by desensitization. The absorption of PAS is worthy of consideration too. Enteric coating may interfere as well as certain adjuvants such as aluminum hydroxide used to offset the unpleasant effects of the drug on the gastrointestinal tract.

In discussing the PAS problem we come at once to the question of what is the best chemotherapy regimen today. From the Medical Research Council (England) and the U. S. Public Health Service control studies we know that isoniazid-PAS or streptomycin-isoniazid-PAS are the best regimens as measured by incidence and speed of sputum culture conversion. The use of roentgenographic clearing as a measure of the relative efficacy of different regimens I consider unreliable. If isoniazid-PAS is as good as all three, why use both of our best agents in one regimen?

Preliminary data from the Medical Research Council indicate a greater emergence of isoniazid resistance with streptomycin twice weekly-isoniazid daily than with streptomycin 1 Gm. daily-isoniazid daily. Streptomycin twice weekly-isoniazid daily has been a rather disappointing regimen at Trudeau Sanatorium from the standpoint of cavity closure. This combination commits the two best agents now available at one time. The use of streptomycin-isoniazid is discouraged for the present; if it is to be used, streptomycin should be used daily rather than twice weekly for the present.

The resection of portions of lung containing cavity persisting during chemotherapy is a great advance in our treatment. The resection of residual nonair-containing, necrotic foci or filled-in cavities during prolonged combined original chemotherapy is another matter.

During prolonged original streptomycin-PAS treatment about 300 patients at Trudeau Sanatorium and Sunmount Veterans Administration Hospital achieved cavity disappearance and negative cultures;

about two-fifths of these had resection. They have been followed for one to four years after the end of streptomycin-PAS treatment. Some unfavorable change has occurred in 15 per cent within three years by Life Table. Frank bacteriologic relapse has occurred in only 5 per cent. There is, as yet, no difference between those with and those without resection.

Nine failures of resection during streptomycin-

PAS treatment, out of 82 resections, have been reviewed carefully; eight of the relapses occurred near the site of operation and not elsewhere in either lung where residual foci were known to exist in five; the ninth case was a pleurisy with effusion on the same side as the operation in spite of there having been cavity on the other side previously. Can resection actually do harm under certain circumstances?

MILIBIS-TAMPAX IN VAGINAL INFECTION

EMIL D. KARLOVSKY, M.D., *New Haven*

THERE are up to 200 preparations listed as effective and even specific for trichomonas infection of the vagina. Practically all of these preparations are designed to be used as local therapy, the main ingredient being variants of arsenicals, picric acid derivatives, carbarsone, lactose, sulfa combinations, thyrothricin, aureomycin, phenyl mercuric acetate, chiniofon and others. Nonetheless, recurrences still continue. However, progress in the fields of paracytology, bacteriology, physiology, endocrinology and laboratory technics has given a better understanding of the problem.

It is accepted that trichomonas vaginalis is the commonest cause for leukorrhea. The incidence of trichomonal vaginitis is reported from 10 to 30 per cent in nonpregnant women and somewhat higher in the pregnant. Kleegman, examining consecutive gynecological patients, reported the presence of trichomonas in 9 per cent. It is now recognized that the presence of trichomonas in the vaginal secretions does not mean that vaginitis is present. In other words, that the trophozoite may be a harmless inhabitant of the vagina, or that certain strains are not pathogenic. For these reasons it has been suggested by some investigators that trichomonads are pathogens only when they are secondary invaders, or when the "four hypos" (hypo-epithelial, -glycogen, -acid, -Döderlein state) are present, thus making an environment suitable for trichomonads to thrive.

Thus far there is no satisfactory explanation as to how this parasite accomplishes its entry, what is the mode of infection, reinfection and transmission.

The Author. *Instructor in Obstetrics and Gynecology, Grace-New Haven Community Hospital, New Haven, Connecticut*

SUMMARY

The author briefly reviews the incidence of trichomonas vaginalis and alludes to the large number of preparations available for the treatment of this condition. In an effort to discover a preparation which will give as good results as those now in general use but at the same time be very simple of application, he describes the Milibis-Tampax preparation, outlines the method of treatment, and presents the results obtained in a small series of patients.

Studies by many investigators have disproved some of the previous theories and have brought forth some new and interesting evidence. The organism is found in the vagina, vulva, urethra, bladder and rectum. Whittington found the trophozoite in 27 per cent of semen specimens in husbands whose wives had infections. However, only 15 per cent of unselected men examined in army camp were found to harbor the organism. In the same study men with non-specific prostatic infection were found to have trichomonads in 34 per cent. That coitus is not the only mode of transfer is shown by examinations of 44 virginal daughters of 25 positive mothers. Thirty-six were found to have trichomonas.

In our clinic we find a significant number of recurrences and/or reinfections. We remain at a loss

to determine the cause for this and we are aware of the problems that are associated with current types of treatment. In the main, such methods either necessitate frequent office visits, they are messy or include cumbersome routines for which clinic patients are not particularly suited. It is obvious also that our advice is not always followed and that once the annoying symptoms of vaginitis are alleviated, the treatment often is forgotten. A number of patients do not even return for follow-up visits. Others when questioned about the prescribed regime admit having abandoned it. It is for these reasons we look for a method by which we can secure at least as good results as those now generally used, but which will be so simple as not to require any additional effort on the part of the patient. The Milibis-Tampax preparation here commented upon more or less meets these requirements.

Description of the preparation: Milibis is bismuthoxy-para-N-glycolylar-sanilate, a derivate of p-N-glycolylarsanilic acid (contains approximately 15 per cent arsenic and 42 per cent bismuth). The activity against *trichomonas vaginalis* has been demonstrated in vitro. Its effectiveness in vivo was determined in 564 cases of trichimonal, monilial and mixed infectious vaginitis with a successful result obtained in 97 per cent of patients.

Tampax is a well known product used to absorb menstrual flow. A number of studies upon the use of vaginal tampons reveal that they do not change the vaginal flora and produce no symptoms of irritation or inflammation. Thus, they apparently do not exert an adverse effect upon a healing cervical erosion (Brand). That tampons play a role in the spread of endometriosis as suggested by Javert is of course a moot question.

The Milibis-Tampax product is a vaginal tampon saturated with Milibis and containing a tablet of Milibis on the tip of the tampax which is inserted first, thus resting in the uppermost portion of the vagina.

METHOD OF TREATMENT

All patients treated were examined and a wet (at times also a dry methylene blue stain) smear was made. Patients were given an adequate supply of Milibis-Tampax and were instructed to use one of these impregnated tampons every night until the oncoming menstrual period. During the menstrual flow they were advised to use as many as needed for the absorption of the flow. The supply given out

varied, dependent upon the number of days each patient menstruated and the severity of the flow in the individual case. This was done intentionally so that the patient would return for restocking before the next period. During this return visit the patient was re-examined and the response to the medication evaluated. It was hoped that in this way we could assure return visits, but the actual experience was somewhat disappointing.

The rationale for this procedure was the belief that the patients would use the preparation every night as advised until the next menstrual period, at which time the symptoms of vaginitis would be annoying enough for the patient to seek relief. After that they would have nothing else to do but to use the impregnated Tampax for the next menstrual flow as for any other flow.

RESULTS

The number of patients treated by this method is relatively small and the follow-up is of too short duration to be able to draw definite conclusions. Seventy-three nonpregnant women were treated in the above outlined manner for trichimonal vulvovaginitis. Twenty patients never returned for a subsequent appointment and are excluded from further discussion. Two patients were unable to tolerate the Tampax. One of these reported immediately after her period at which time a wet smear was negative for trichomonas and clinically she was improved; nevertheless, she was given another preparation. The other patient discontinued the Tampax after two days and she also was placed on another regime. Two patients had an aggravation of trichomoniasis, both symptomatically and by wet smear examination. In both of these patients the vaginitis was worse clinically. Two patients showed no change clinically or by wet smear examination. Two patients had no symptomatic improvement, but the smears were negative for trichimonads. Four patients were symptomatically and clinically improved, but the smears showed persistence of trichimonads. These 12 cases are considered as failures, and comprise about 20 per cent of the series.

Forty-one patients were considered as improved: thirty had a negative smear; eleven were not examined by a smear. Eight patients had a one-month follow-up. Eight had a two-month follow-up. Thirteen were followed for three months. Eight at the completion of four months were still negative. Four remained cured for over four months.

In two patients of the above the infection recurred. One of these patients had a double vagina and cervix, the infection continuing in the smaller cavity, eventually reinfecting the other.

Ten nonpregnant women with mixed bacterial vaginitis were treated in the same manner. All of these patients returned for a follow-up examination. Every one of these was clinically improved. Methylene blue stain confirmed this improvement. Seven of these patients remained asymptomatic after the third menstrual period.

The series reported is small and the follow-up too short for any definite conclusions to be drawn. Eighty per cent of patients with trichomonal vaginitis were considered as improved. This is a smaller number of cures than generally reported with other regimes but we believe that the Milibis is as effective as any other antitrichomonal agent used. Nevertheless, the method needs further trial, especially longer use individually, for at least four menstrual periods. A majority of the patients were pleased with the method as a therapeutic measure. A number of the

cases in this report are recurrences and previously were treated with other agents. This latter group commented especially favorably on the use of the medicated Tampax. None of the patients in this group had any reaction to Milibis. Caution, however, seems to be indicated in cases of known or suspected hypersensitivity to arsenic. Ten patients with mixed infections gave good response.

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HOW TO BE A GOOD MEDICAL WITNESS

JOSEPH L. SPRAY, JR., *Los Angeles*

The Author. *Of Spray, Gould and Bowers*

IF IT hasn't happened to you already, it will in a matter of time. You will receive a telephone call from an attorney soliciting your services as an expert witness. The chances are the request will be in connection with one of your patients who has been involved in an automobile accident and who has brought suit for his injuries.

The prospect of disrupting your daily routine to go to court is not pleasing, nor is the thought that once you arrive there your observations and opinions may be assailed. But there need be no misgivings about testifying in court; your apprehensions will be more fancied than real, if you know how to be a good witness.

Be courteous to the attorney; he is also a professional man. He does not expect your professional services for nothing, and you may rest assured that he will make every effort to see that his client reasonably compensates you for your time and trouble in appearing in court.

During the initial telephone call, or at a later conversation, the attorney will ask you to explain the patient's condition, perhaps in considerable detail. Remember that the attorney is not a man of science. Give him a few minutes of your time and, in lay terms, the information he desires. He cannot perform his professional duty unless he has a thorough understanding of the medical aspects of his case in advance of the trial.

A medical witness is not an advocate but should be impartial to both sides. He should not lose sight

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of the fact that he is called as a disinterested expert to assist the court and jury in resolving the medical problems at hand. A display of partisanship, insincerity or temper on the witness stand will cast suspicion on your testimony and serve to discredit your profession. You will perform your part in the trial by candidly describing the patient's injuries and prognosis.

Before going to court you should read through your records at least once and preferably twice. You will not be expected to know every minute detail of your patient's case, but you may be embarrassed if, after testifying in your direct testimony that your patient sustained a Colle's fracture of the right arm, it appears from your notes and the hospital records that the Colle's fracture was of the left.

Surprisingly enough, such important discrepancies are not uncommon and obviously can be easily avoided by refreshing your memory by a brief review of your file a few minutes before taking the stand. You will be surprised how such a review will recall many important matters not in your records.

Be sure and bring with you all of your charts, x-rays and other written material concerning the treatment of the patient, as the attorneys have an absolute right to inspect such papers. If you do not, you may be needlessly inconvenienced and delayed. The judge, if counsel requests, may order you to return to your office to obtain the missing documents.

When you take the stand you will be asked to relate to the court and jury the history the patient gave you. Ordinarily this phase of your court appearance will present no problems. You will then be asked to give your findings and this request will entail both objective and subjective complaints.

Counsel will ask you whether in your opinion the patient's condition is a proximate result of the trauma. This question is the very heart of the law suit, for if the condition is not traumatic and is unrelated to the accident, your patient has no legal case. This question may suggest many difficult subsidiary problems. Has there been an aggravation of a pre-existing traumatic condition? If so, in what par-

ticular? What degree? But you will easily overcome these and similar problems if you give a little thought to them before trial.

Again, you will be asked when you take the stand what temporary and what, if any, permanent disabilities you believe are attributable to the accident.

With reflection before coming to court you should have no difficulty with this problem, but if you are so busy in the office or hospital that you wait to do your thinking aloud on the witness stand, you may be embarrassed.

You should not lose sight of the obvious fact that your time and effort on the witness stand will be wasted if you are not understood. The jurors know little, if anything, about medicine. To overcome this hurdle you will make a conscious effort to express your thoughts in lay terms, to use technical language only where really necessary. Otherwise, the jury may know little more when you leave the stand than when you took it.

IMPORTANT DIFFERENCE

A good medical witness realizes the important difference between the role of the medical lecturer and the medical witness. The former is often called upon to discuss abstract academic problems, the latter never is.

In the case of the medical expert, the subject is always living and usually sitting in the court room. The judge and jury will be looking for tangible help from you to solve the medical questions at issue. They are not interested in academic possibilities, but in the probabilities of the case.

You will be careful to testify only about reasonable medical certainties. Otherwise you may find yourself in the midst of disconcerting legal objections because your testimony is in the realm of speculation and conjecture, immaterial to the medical issues. Again, you should answer all questions as directly and definitely as possible and resist the temptation of the lecture hall to occasionally digress to interesting collateral points.

It is not difficult to be an expert medical witness if you know and practice the basic rules.

30th CONNECTICUT CLINICAL CONGRESS
of the
CONNECTICUT STATE MEDICAL SOCIETY
and the
YALE UNIVERSITY SCHOOL OF MEDICINE

YALE-NEW HAVEN MEDICAL CENTER

SEPTEMBER 14, 15, 1955

The 1955 Clinical Congress will be presented in two days and all of the meetings will be held at the Yale-New Haven Medical Center.

Two sessions will be held simultaneously in different auditoriums giving a broad selection of topics. Material in the fields of diabetes, cardio-vascular disease, biliary tract surgery, poliomyelitis, hepatitis, new drug therapy, clinicopathological conferences, and other related subjects will be presented.

Registration admitting to all sessions will be \$3. Medical students, interns, and residents will be the guests of the Congress, if properly certified. Cafeteria luncheons will be available.

MAKE A NOTE OF THESE DATES ON YOUR CALENDAR

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EDITORIALS

The AMA Comes to Boston

New England physicians will have the honor and privilege of being hosts to their fellow practitioners from all over the United States at the Clinical Session of the American Medical Association to be held in Boston, November 29 through December 2, 1955. The six New England State Medical Societies are desirous of making this a most successful and worthwhile meeting. To accomplish this end physicians in New England have been asked to submit proposals and suggestions for presentations.

In the June issue of the JOURNAL appeared a notice concerning the submitting of papers for presentation at the Clinical Session. Elsewhere in this issue under Letters to the Editor appears a communication regarding the television program. Those who carry the responsibility of the scientific program want representatives from Connecticut as well as from the other New England States participating in the presentation of scientific papers and in the television demonstrations.

There will be little excuse for any physician in Connecticut missing the sessions in Boston this autumn. With excellent roads the Bay State capital is readily accessible to all, and if you find it impossible to remain through all four days you at least should plan to be on hand for a part of the time. There is an obligation entailed here as well as an opportunity. Although the sessions will be held within the geographical boundaries of the Massachusetts Medical Society, yet the Connecticut State Medical Society with its neighbors in New England

will share in the responsibilities incumbent on any host. After all, it was but a little over three centuries ago that those hardy souls came down from the Massachusetts Bay Colony to settle in our fertile valleys.

Save the dates—November 29 through December 2.

The Addict

Dr. Abraham Wikler, chief of the neuropsychiatric section of the National Institute for Mental Health Addiction Center of Lexington, Kentucky, has an article in this issue on the rationale of the diagnosis and treatment of addiction. He discusses primarily narcotic and barbiturate addiction, mentioning alcohol and amphetamine only to point out that they pose different problems requiring different handling.

Addiction is defined by the United Nations Expert Committee on Drugs Liable to Produce Addiction as follows: "Drug addiction is a state of periodic or chronic intoxication detrimental to the individual and to society, produced by the repeated consumption of a drug natural or synthetic. Its characteristics include: (1) An overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means. (2) A tendency to increase the dose. (3) A psychic and sometimes a physical dependence on the effects of the drug."

The clinician, however, can diagnose drug addiction only when an "abstinence syndrome" is demonstrable. Dr. Wikler describes the symptoms characteristic of narcotic and barbiturate withdraw-

al. He points out that the two are often combined as would be expected in his case material. When this condition is present, narcotics are withdrawn first since barbiturate withdrawal is a prolonged process and quite dangerous. He quotes eighty per cent of barbiturate addicts suddenly withdrawn as having convulsions. This is in patients taking 15 grains of a short-acting barbiturate daily for six weeks. This seems an unusually high incidence of convulsions in a relatively mild addiction of short duration. There are probably other factors involved.

Another question, which is not discussed in the article, might be considered as to the number of barbiturate addicts without narcotic involvement seen at Lexington. The legal difference in status between a narcotic and a barbiturate addict is very similar to that between a narcotic addict and an alcoholic. Since the possession and use of barbiturates is not a crime in most States, it seems unlikely that many pure barbiturate addicts would be sent to Lexington. This is, however, a side issue but a significant one.

The pharmacodynamics of addiction given are the standard ones found in the textbooks.

A very significant point in the discussion of the psychodynamics of addiction is the concept of a low "boredom" threshold in addictive personalities. This boredom is difficult to define, but certain articulate addicts whether barbiturate, narcotic or alcoholic can often describe it quite well. One patient has called it a sort of "psychic nausea without end." It is not an acute state but rather a low grade dysphoria peculiar to addicts or potential addicts. Finding existence as it is "boring," they change their awareness of it by chemical means. Eventually they become true devotees of altered consciousness.

Although distressed persons take drugs or alcohol to relieve various anxieties, depressions, and tensions, only a few become addicts and these are not always the most anxious or depressed nor the heaviest consumers of the drug. In this connection it is interesting that Dr. Wikler states that most of his cases on psychological testing are "psychopathic" rather than "neurotic." However, he is dealing with a very selected group with certain common sociological and situational characteristics.

There are few new ideas in this paper but the overall picture of the present day approach to the diagnosis and treatment of addictions is interesting and instructive.

Dr. Murdock Re-elected AMA Trustee



Thomas P. Murdock of Meriden was unanimously re-elected to the Board of Trustees of the American Medical Association by the House of Delegates at the recent session in Atlantic City. The large number of delegates from different States who rose to second the nomination presented by Thomas J. Danaher was conclusive evidence of the esteem and affection with which Dr. Murdock is held by all the members of the House. Our Society is extremely proud of its most distinguished medical statesman.

Conflicting Expert Testimony

The recent statement made by Superior Court Judge Thomas J. Molloy, as quoted in the press, to the effect that the "utter conflict" in most fields of expert testimony and among the medical profession in particular is scandalous is an indictment which is serious. If it is justified the time has come for our profession to clean its own house and forever obviate the existence of such a situation. Elsewhere in this issue of the JOURNAL will be found an attorney's concept of what constitutes a good medical witness. Attention is directed to the statement that "a medical witness is not an advocate but should be impartial to both sides."

It is conceivable that two or more expert medical witnesses might express conflicting opinions as to the proper method of treatment in a given case but this could hardly be said of a statement of objective findings. To be a good medical witness, as Mr. Spray has said, one must be impartial in presenting the facts. If an expert opinion is misstated knowingly we have no better authority than that of Louis J. Regan, M.D., LL.B., a member of the State Bar of California, who warns that such misstatements "will incur legal liability for the fraud or deceit."* If to arrive at the correct solution, expert medical witnesses are placed on the stand who do not possess the requisite skill and knowledge to give their answers probative force or value, then such witnesses should not be qualified as expert.

Judge Molloy, in the course of his remarks referred to above, is said to have stated that the situation "is reaching the point now in the field of expert testimony where judges, lawyers and the courts are thinking of setting up independent panels to give expert opinion." This is not a new idea and it may strengthen the position of the conscientious medical witness as well as aid the courts in solving a knotty problem. To say that it will be difficult to find enough completely independent physicians to staff such a panel is not sufficient reason for not making the attempt.

The Tuberculous Pregnant Woman

It may be surprising to many of our readers to learn that the incidence of therapeutic abortion in the presence of pulmonary tuberculosis continues to be high in some institutions. Schaefer of the Departments of Obstetrics and Gynecology, Cornell University Medical College and New York Lying-In Hospital, is the authority for this statement.† Most writers today, however, agree that therapeutic abortion for pulmonary tuberculosis is not indicated after the first trimester of pregnancy. Some are still advocating therapeutic abortion in the presence of active pulmonary tuberculosis during the first trimester. Schaefer's figures show that in the presence of active disease pregnant women do better when treated actively and carried through to term rather than when the pregnancy is interrupted.

It is important to recognize pulmonary tubercu-

losis early and this is doubly important if the patient is pregnant. By taking roentgenograms routinely on all antepartum patients at the New York Lying-In Hospital the incidence of pulmonary tuberculosis has been found to be three or four times as great as it was before this procedure was instituted.

With modern chemotherapy—streptomycin, para-aminosalicylic acid, isoniazid—the medical treatment of pulmonary tuberculosis has been greatly strengthened but there still remains no substitute for bed rest as a basis for all treatment. Pneumothorax is indicated in pregnancy just as when the tuberculous woman is not pregnant. A number of reports have been published of thorocoplasties performed during pregnancy with good results and the several stage operation is now an accepted procedure during pregnancy at many large tuberculosis hospitals. Lung resection in the presence of pregnancy has its advocates but as yet an insufficient number of pregnant women have undergone this procedure to afford a true evaluation.

When it comes to the obstetric management of the woman with tuberculosis there is a definite trend away from cesarean section in the absence of obstetrical indications unless either a prolonged labor or difficult forceps delivery is anticipated. The safest type of labor for these women would seem to be carried out with no analgesia terminated by low forceps under conduction anesthesia. For those requiring analgesia small repeated doses are advocated, if necessary, of pentothal sodium and meperidine. Morphine and scopolomine should be avoided.

It has been proven quite conclusively that pregnancy does not necessarily have a deleterious effect upon pulmonary tuberculosis, either active or inactive. Early diagnosis and adequate therapy are the fundamental prerequisites for good results. There is no reason to expect any but a normal child from a tuberculous woman.

Administration and Research

I have been reading the late George Heuer's "Dr. Halsted," a brief biography of a man who, in the opinion of many, possessed the most original, brilliant and productive surgical mind that has so far appeared in the American medical field. At one point in the book* there is a quotation from a dis-

*Medical Malpractice, C. V. Mosby Co., 1943

†N. Y. State Journal Med. 55:8, April 15, 1955

*Dr. Halsted by George W. Heuer, Suppl. to Bull. Johns Hopkins Hosp., 1952, 90, 83.

tinguished German surgeon who, on his departure from America after an extensive survey of American surgical clinics remarked to Dr. Heuer: "You have one great fault in this country; you select your most brilliant young men as heads of your departments and then destroy them with routine." Dr. Heuer described the pains which Halsted took to escape this tragic fate by avoiding attendance at meetings in spite of the criticism of some of his colleagues, and by delegating his administrative duties to his chief resident and senior interns. He admits that this resulted in a rather loose organization but that on the whole it worked well.

The statement of the German surgeon was, judging from a considerable experience in university teaching and administrative work, in the main correct. There is a very definite tendency, not only in medical schools but also in colleges and universities, to appoint the heads of departments on their record as researchers and quite frequently to then swamp them with routine administrative work. If this estimate of the situation is correct and no doubt there are some exceptions, the question is—what can be done about it? There is little doubt that real research capacity based on originality of mind is infinitely less common than good administrative ability and, in the writer's opinion, the two qualities are not often combined in the same person. It would be foolish to claim that a great creative scientist is never a good administrator, for the one thing predictable about human beings is that they are unpredictable. It is, however, pertinent to enquire whether, given a department headed by a brilliant investigative scientist, it is necessary to burden him with a lot of deadening routine? No one, I think, with experience in scientific research will deny that its successful fruition requires much uninterrupted time, thought, and work. Nor do I think that anyone will claim that the majority of heads of departments in most universities are investigative geniuses. Such men are rare and should be conserved. On the other hand any one who has attended the numerous faculty and committee meetings generally assigned to the head of a department is well aware that, while some matters of prime importance are discussed, a good deal of time is consumed in considering what, to an active minded investigator, must be matters of dreary routine. While Halsted's somewhat haphazard solution of the problem may not be the best

one, it is seldom that in a university department there are not one or more men who are interested in and capable of administrative work. There would seem to be no valid reason why this should not be delegated to them. Indeed it seems highly desirable that every department should contain men of different types. That a clinical department should be headed by a trained and experienced clinician seems essential but if he is of the investigative type he should no more be swamped by routine clinical work than by routine administrative work. Good teachers are essential and all investigators are not good teachers. In the opinion of the writer some teachers accustomed to contact with private rather than hospital patients are desirable. The problem is not a simple one and no rigid blueprint will fit every situation. It is a problem of building up a workable machine in which mutual understanding and co-operation is the chief lubricant.

G. B.

Honorary Degree Presented by Colgate to Dr. Howard S. Colwell

Howard S. Colwell, New Haven, was awarded the honorary degree of Doctor of Science at the 134th commencement exercises at Colgate University.

Dr. Everett Case, president of the University, presented the degree and read the following citation:

"Enemy of man's enemies, in medicine and other fields as well, your career as doctor, teacher and ambassador extraordinary to Yale has brought fresh distinction to your Alma Mater. Proud of its adopted sons, Colgate salutes today in you the character and achievements she delights to honor in her own."

Dr. Colwell has served on the faculty of the Yale University School of Medicine for a number of years and is attending physician at Grace-New Haven Community Hospital. Following graduation from Colgate University, he attended Johns Hopkins University School of Medicine where he received his medical degree in 1914. He is a diplomate of the American Board of Internal Medicine and an active member in local, State and national medical associations.

PROGRESS IN CLINICAL MEDICINE

NEW DRUGS IN THE TREATMENT OF HYPERTENSION

LAURENCE E. HINES, M.D., *Chicago*

HYPERTENSION, which is probably the price we pay for living in a complicated civilization, has made civilization of the medical world still more complicated by the efforts of its investigators to find a cure. In the past few years prodigious efforts have been made to understand the mechanism and we have accumulated some sketchy knowledge of the etiology and genesis of hypertension. This knowledge serves as the basis for rational therapy.

In discussing the therapy of hypertension we must keep in mind that hypertension is not a disease but a symptom such as fever. At times fever per se becomes harmful and must be treated. In a similar manner hypertension must be treated, and fortunately at the present time we are in an era where the development of hypertensive drugs has been fruitful.

In a general way we use hypotensive drugs for patients in which an established etiology such as surgical urogenital disease (prostatism, pheochromocytoma) have been excluded and in which simple measures such as weight reduction and psychotherapy have failed.

TABLE I
DEFINITION

90 diastolic } Life insurance
140 systolic } Traditional

UPPER LIMITS OF NORMAL (MASTER)

AGE	SYSTOLIC	DIASTOLIC
16	145	90
20	150	95
30	155	98
40	165	100
50	175	106
60	190	110

Let us first define hypertension. It is traditional to consider readings above 140 systolic and 90 diastolic as hypertension. Master believes the upper

The Author. *Professor of Medicine, Northwestern University Medical School, Evanston, Illinois*

SUMMARY

A systematic method of procedure in the treatment of hypertension is described. The methium salts have more marked hypotensive action, but because of toxic effects should be used only in the more severe types which have failed to respond to simple measures. Hydralazine may also be used in combination with, or as a substitute of the methium salts in the severe case. Rauwolfia preparations are useful drugs alone in the mild cases, and as an adjunct in the severe cases.

limits of normal may reach levels shown in Table I. Impairment studies in the insurance field do not accept the values proposed by Master. Adherence to the traditional concept of 140 systolic, 90 diastolic is adhered to by insurance examiners.

TABLE II
CLASSIFICATION OF SEVERITY OF HYPERTENSION

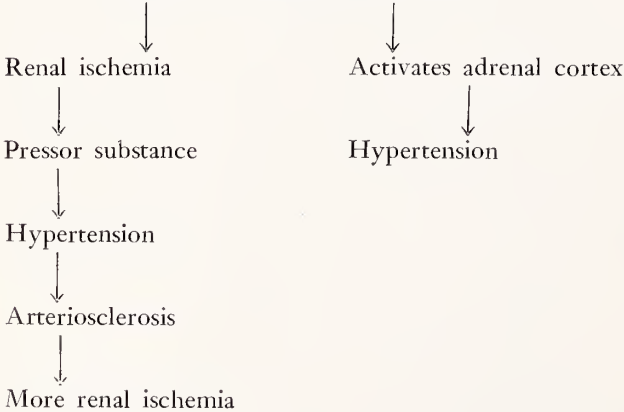
- MILD BENIGN
- Minimal retinal changes
Persistent abnormal pressure
- SEVERE BENIGN
- Retinal
Cardiac
Renal
Cerebral
- } Varying degrees of structural changes
- Functional changes from hypertension
- MALIGNANT
- Hypertensive neuroretinopathy
Rapidly progressive renal failure
Postmortem arteriolar necrosis

From a therapeutic standpoint it is more important to classify the state of severity of the disease rather than to define. If it is necessary in a borderline case to define the presence or absence of hyper-

tension, we should individualize and not adhere strictly to a rigid definition. A classification in common use is shown in Table II. The mild benign type generally can be controlled by simple measures without resorting to hypotensive drugs. When simple methods fail, drugs are indicated to reduce blood pressure in the severe benign and malignant classes.

It is necessary to have a knowledge of the etiology to treat rationally and in Table III some of the factors pertaining to the etiology are outlined. Of course there are many defects in our knowledge of the cause of hypertension and the table is necessarily sketchy but it contains the chief essentials. It has been known for a long time that psychiatric disturbances are often causative factors in producing hypertension. A variety of suppressed psychic disturbances are capable of stimulating the sympathetic nervous system which in turn can activate the supra-renal cortex and cause elevation of the blood pressure. The sympathetic nervous system stimulation also may cause renal ischemia and this may result in the release of pressor substances capable of producing more hypertension. As the result of the insults from hypertension from two sources, structural changes may be produced in the vascular system and thus more renal ischemia is produced and more pressor substances cause still more hypertension. Therefore it becomes plain that our therapeutic efforts must be directed toward interrupting some portion of this chain.

TABLE III
PROBABLE FACTORS IN ETIOLOGY
Repressed psychic disturbance
Stimulation of sympathetic N. S.



When we study the pharmacology of hypoten-
sive drugs, the successful ones produce lower blood

TABLE IV
BASIC THERAPY FOR HYPERTENSION
Correct mental maladjustment
Eliminate overwork
Low calorie diet for obesity
Moderate sodium intake
Sedation

pressure by virtue of actions against one or more etiologic factors. In Table V the principal pharmacological actions of three classes of drugs are listed. The discussion does not cover the actions or merits of such drugs as thiocyanates, nitrites, veratrum derivatives, the pyrogens, the adrenergic blocking drugs, or antirenin. My discussion chiefly concerns methonium salts, Rauwolfia, and Hydralazine.

TABLE V
THERAPEUTIC ACTIONS
METHONIUM SALTS
Blocks sympathetic and Parasympathetic nerve ganglia
RAUWOLFIA
Tranquilizing effect without cerebral depression
HYDRALAZINE
Combats pressor substances

First, the methonium salts are perhaps better understood pharmacologically and are perhaps more definitive than the other drugs because they implant a block at a specific site, namely, at the sympathetic and parasympathetic ganglia. This block inhibits peripheral and renal vasoconstriction in a manner somewhat similar to that achieved by surgical sympathectomy. This drug like the others only controls the hypertension. It does not cure.

Second, the action of drugs obtained from the crude root of Rauwolfia Serpentina is primarily one of depression of the vessels of the central nervous system. It does not block the peripheral sympathetic nervous system or the sympathetic ganglia. It has no effect on the pressor substances in the blood stream. A slowing of the pulse rate and the production of a feeling of tranquility in the high strung patient are produced. It is particularly valuable alone for its sedative effect in the mild hypertensive and as the cornerstone in conjunction with the stronger drugs in the severe benign and malignant cases.

Although the action of Hydralazine is not well understood, its mechanism is probably one that

combats the pressor substances in the blood stream. It also causes dilatation of the renal vessels.

In any given patient one cannot predict the dose needed. Neither can it be predicted whether single drugs or combinations are required. The dose of the methonium salts varies from 125 mg. to 600 mg. four times daily. The dose of Hydralazine varies from 25 mg. to 200 mg. four times daily. The doses of the various Rauwolfia preparations are shown in Table VI.

TABLE VI
RAUWOLFIA SERPENTINA

	NAME	DAILY DOSE MG.	TABLET MG.
Crude root	Raudixin	200 to 1000	50 to 100
Alkaloidal extract (Alseroxylin)	Rauwloid Rautensin	4 to 16	2
Single alkaloid (Reserpine)	Serpasil Serpiloid Reserpoid	0.5 to 3.0	0.1 to 0.25

In recent years various drug combinations have been widely studied. In particular, combinations of methium and apresoline (Hyphex) have been shown to be very effective. Schroeder and others have published detailed studies about this combination. Although their results have been favorable, the high incidence of unpleasant drug effects has led to more extended search for better drugs and better combinations. Rauwolfia, a drug of a new type, has been added and used not only alone but in combination with others. Most recently a promising drug, Pentolinium, has been introduced and studied by various investigators. Known as Pentolinium Tartrate (Ansolylin) it is like the methonium salts, a ganglionic blocking agent. It was first synthesized by Libman, Pain, and Slack,³ studied experimentally on animals by Wein and Mason,⁴ and more recently studied clinically by Smirk of New Zealand,⁵ and Freis⁶ and others in this country. A comparison of this drug with Hexamethonium revealed that it is five times more potent; has a hypotensive effect 40 per cent longer; produces a more predictable response when given orally; and is less likely to produce constipation and other bad effects. Smirk believes that the aim of the drug is to reduce the standing systolic pressure to about 120 systolic. If it falls much more there will be faintness which can be removed by assuming the sitting posture. Pentolinium of course has not been studied enough to draw final conclusions. It appears promising because it is easier to establish a dose, and there seem to be fewer unwanted effects from this brand of methonium.

TABLE VII
PENTOLINIUM

(A methonium salt)

Claimed advantages (Smirk) in conjunction with Rauwolfia

1. Adequate orally
2. Course of action prolonged
3. Closer approach to ideal 24 hour control
4. Smaller doses needed
5. Aim of therapy to reach 120 systolic in the "trough"

TABLE VIII
UNWANTED EFFECTS OF METHONIUM SALTS

Symptoms of orthostatic hypotension
Blurring of vision
Dryness of mouth
Hypotonicity of bladder
Impotence
Cold intolerance
Constipation
Obstruction of hollow viscera
Embolic
Hypoglycemic reactions in diabetes

There is probably no class of drugs which produce more undesirable effects and which have been more difficult to control than the methonium salts (Table VIII). Orthostatic hypotension is a characteristic effect and an evidence that there is therapeutic value from methonium salts. The symptoms of this syndrome are dizziness, giddiness, or weakness, or faintness when the patient is standing. The symptoms, quickly relieved by sitting or lying, may be used to establish the maximum dose at a given time. For example, Smirk deducts 10 to 20 mg. from the dose which produces these symptoms of hypotension. Blurring of vision and mouth dryness are probably caused by the action of the drug on the parasympathetic ganglia. Hypotonicity of bladder, sexual impotence, and constipation are commonly undesirable effects. In severe overdose, obstruction of hollow viscera (stomach, bowel, bladder) is possible. When the hypertension state is associated with structural damage in the heart and vessels, detachment of thrombi with embolic results has occasionally occurred. In the diabetic who is receiving insulin, control of diabetes may be hindered and hypoglycemic reactions produced.

Hydralazine, a very important hypotensive drug, is probably more difficult to use than any other drug because of toxic effects. The symptoms (Table IX) are coryza, headache, conjunctival injection, tachycardia, lassitude, nausea, and fever. Occasionally an attack of angina pectoris is precipitated. Skin rashes may occur. Most seriously a fatal collagenous disease similar to Lupus Eryth with joint symptoms has developed.

TABLE IX
UNWANTED EFFECTS OF HYDRALAZINE

Headache
Coryza
Conjunctival injection
Lassitude
Nausea and vomiting
Angina pectoris
Fever
Skin eruptions
Joint involvement
Collagen like disease

Because of the many drugs, diets, and gadgets available for the treatment of hypertension, it is important for every physician who treats this disease to have a system. Otherwise the patient may not live long enough to exhaust the list. Although thiocyanates, veratrum preparations, pyrogens, etc., have real merit occasionally, they are not included in this discussion. It goes without saying that one should make an adequate clinical study to rule out congenital cystic disease of the kidneys, coarctation of aorta, chronic suppurative nephritis, prostatism and other urologic diseases. The study will also allow proper classification into mild benign, severe benign, or malignant types. After advising the patient to take more rest, to diet if obesity is present, to straighten out his mental maladjustments, to restrict the sodium of his diet, he may be given a mild sedative for insomnia and restlessness. On this therapy which has been labeled Basic Therapy (Table IV), many patients after a period of one or two months will be cured and a great improvement may occur in those we have called "severe benign." If no results have developed within this period of two to four weeks Rauwolfia is added, starting with 50 mg. b.i.d., and if necessary increasing step by step the dose to as much as 200 mg. b.i.d. More time passes and if hypertension persists one of the methonium salts is added. This drug is more powerful and the proper dose arrived at only after careful study. In any given patient neither the effectiveness nor the correct dose is predictable. A common initial dose when Pentolinium is used is 20 mg. t.i.d., with increases at necessary intervals in the severe types to as much as 300 mg. t.i.d. The proper dose according to Smirk is one which brings the systolic pressure to 120 at the time of greatest effectiveness of the drug. This time occurs from two to four hours after an oral dose and may be associated with symptoms of hypotension. If these symptoms are consistently produced, about 20 mg. is deducted from the dose. Sleeping in a sitting posture is recom-

mended to maintain this postural effect at night without awakening the patient for a dose. Hospitalization, or training the patient to record his own pressure, or frequent morning visits to the doctor's office may be needed to establish correct dosage.

If after a reasonable time adequate response fails or the symptoms from the drug are too unpleasant, Hydralazine may be substituted for the methium salt or the methium dose may be reduced and Hydralazine added to the two previously prescribed drugs. When methonium salt is used, Neostigmine or a laxative may be used for the gastrointestinal symptoms; pilocarpine may be used for mouth dryness. Because of great dose variability, there is no place in the therapy of hypertension for multiple drugs in the same pill or capsule.

Special mention is needed in this discussion for malignant hypertension. We have defined the condition simply as severe persistent diastolic hypertension with extensive neuroretinopathy and rapidly progressing renal failure. For many years this syndrome was considered to be a hopeless clinical state for which there was no significant treatment. Later, sympathectomy offered some hope. Now we have drugs and combinations of drugs which offer a genuine hope for this class of patients. Hyphex under careful control, and combinations of Rauwolfia and the methonium salts have achieved significant cessation of renal failure, uremia and retinopathy. The method used to determine the correct dose must be exact and more radical than that employed in the milder types. When we have arrived at the conclusion that the patient is in a malignant phase, Rauwolfia and Pentolinium are started together and the dose rapidly increased, at two day intervals until maximum amounts are reached. Hydralazine is added if good results are not obtained. Hospitalization, radical salt restriction and complete rest are necessary adjuncts.

TABLE X
METHOD OF PROCEDURE

Adequate clinical study
Classify for severity
Institute basic therapy (Table IV)
Observe 1 to 2 months unless malignant type
If no results start Rauwolfia in
 increasing doses to 500 mg. daily
Pentolinium or Methium is added
Substitute Hydralazine for Methium
 drug or use as addition
Accurate and careful dose control of
 Pentolinium and Hydralazine

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Dr. Paul Heads Association of American Physicians



JOHN R. PAUL, M.D.

Connecticut may well be proud of the selection of the new president of the Association of American Physicians. John R. Paul, professor of preventive medicine at Yale, is one of America's most distinguished physicians and rightfully deserves this new honor which has been accorded him. A graduate of Princeton and of Johns Hopkins School of Medicine, Dr. Paul has served as assistant in pathology at Hopkins, instructor in surgical pathology at

Pennsylvania, instructor in pathology at Jefferson, and for the past 27 years a professor at Yale in the department of medicine.

His work in the Armed Forces during and following World War II was outstanding. During the period 1941-1946, while serving as consultant to the Secretary of War and director of the Commission on Neurotropic Virus Diseases, Dr. Paul spent ten months in the Near East pursuing studies on sandfly fever, poliomyelitis and hepatitis, and four months in Japan studying Japanese B encephalitis. After the close of the war he made annual trips to Germany to study hepatitis in the U. S. troops there and after these assignments was sent to Fort Barrow, Alaska to study poliomyelitis immunity among the Eskimos. Then it was in turn French Morocco, Korea, and Cairo, Egypt for further studies.

Dr. Paul's work on poliomyelitis is well known including his part in evaluating gamma globulin in the prophylaxis of this disease. His fame is international and honors have bestowed upon him commensurate with his desserts. Connecticut medicine is proud to claim him as one of its own.

Dr. Upson Elected President of Connecticut Public Health Association

William Hart Upson, M.D., director of health, Suffield, was elected president of the Connecticut Public Health Association at the Annual Meeting of the organization, May 18 at Cedarcrest Sanatorium, Newington.

Dr. Upson succeeds Dorothy Wilson, R.N., Doctor of Education, New Haven, president of the Association during the past year.

Edward M. Cohart, M.D., associate professor of Public Health, Yale Medical School, was named president elect; Leonard F. Menczer, D.D.S., Hartford, vice president; Mrs. Claire Reinhardt, West Hartford, secretary; and Mrs. Eloise K. Erkler was reelected treasurer.

Members who won election to the Board of Directors were Erval R. Coffey, M.D., Greenwich; Stanley Wedberg, PH.D., Storrs; and Miss Ann Switzer, Hartford.

Eric Mood, New Haven, was chosen delegate to the American Public Health Association and Harold S. Barrett, M.D., Manchester, was chosen alternate delegate.

THE PRESIDENT'S PAGE

THE WAR YEARS

OUR first office, 258 Church Street, was on the corner of Grove and Church in New Haven. To reach it you opened the door, passed a dress shop, walked upstairs, turned to the left and "there you are."

Just fifteen years ago, with the advent of a full time executive staff, our office became a virtual "bee hive" of activity. It became the central meeting place for our many committees, the members of which were cognizant of the importance of their assignments. Their reports show the valuable contributions made available to them by our staff.

The importance of your Society's position as a "Demiourgos," i.e., "a worker for the people," was thoroughly demonstrated after Pearl Harbor, December 7, 1941. Its office became the center of all medical activities pertaining to the war effort. Our Executive Secretary, Dr. Creighton Barker, became the hub around which revolved these activities. He was ably assisted by the physicians throughout the State. As time went on he became busier than a "hen on a hot griddle." He assumed the chairmanship of the Federal Procurement and Assignment Service for Connecticut, Consultant to the War Manpower Commission in the Division of Professional and Scientific Personnel. In 1941 the State Examining Board moved its office to our headquarters and Creighton Barker became its official secretary.

Monthly our JOURNAL kept our members up to date on all these developments. It was progressive in character and the March, 1941 issue appeared clothed in a new cover with a border of colonial red. The improved format with clearer type and better quality paper made for easier reading, evidence of the alertness of our Editor, Stanley B. Weld, and his Editorial Board.

With these increased services it soon became evident we must have more office space. The Council appointed a committee to explore the possibilities of acquiring a home of our own. This will be discussed in a subsequent letter.

Oliver L. Stringfield, M.D.

CHAIRMAN OF THE COUNCIL



C. LOUIS FINCKE, M.D.

C. Louis Fincke, Stamford, was recently elected chairman of the Council of the Connecticut State Medical Society.

Dr. Fincke succeeds Thomas J. Danaher, Torrington, who has resigned to devote more time to his duties as vice president of Connecticut Medical Service and chairman of the CMS Professional Policy Committee.

Dr. Fincke has served on the Council as a representative from the Fairfield County Medical Association since 1952. He is a director of medical services and chairman of the Medical Board at Stamford Hospital.

A diplomate of the American Board of Internal Medicine, he is attending physician at St. Joseph's Hospital, Stamford, consulting physician at Stamford Hall Sanatorium and a member of the Board of Directors and the Medical Advisory Committee, Gaylord Farm Sanatorium, Wallingford. He is an incorporator and member of the Connecticut Society of American Board Internists.

Dr. Fincke has served as one of the five members of the Connecticut Medical Examining Board since 1953. He is a past president of the Stamford Medical Society and a member of the Fairfield County Medical Association and the American Medical Association.

Dr. Fincke is a graduate of Harvard University and received his medical degree at Harvard Medical School in 1928. He served as an intern, resident and instructor in medicine at the University of Rochester Medical School from 1928 to 1931. From 1931 to 1942 he was an assistant in medicine, College of Physicians and Surgeons, Columbia University, and assistant physician, Vanderbilt Clinic, New York City.

He is engaged in the private practice of internal medicine in Stamford and resides with his family in Darien.

THE SECRETARY'S OFFICE

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Duties of the Committees

STANDING COMMITTEES

COMMITTEE ON ARRANGEMENTS

Article X, Section 3, Par. 1 of the By-Laws of the Society provides:

The Committee on Arrangements shall be appointed by the component county association with which the Annual Session of the Society is to be held. It shall provide suitable accommodations for the meeting place of the Society, and of the Special Sections, and of the House of Delegates, and of their respective committees. Its chairman shall report an outline of the arrangements to the Executive Secretary for publication in the program. The report of the Committee to Survey the Annual Meeting adopted by the House of Delegates on May 1, 1951 recommended that the chairman and one other member of the Committee on Arrangements, for the meeting in the year immediately preceding, serve with the Committee on Arrangements from the association in the county where the annual meeting is to be held. It was further recommended by the Committee to Survey the Annual Meeting, and adopted, that the Local Committee on Arrangements should be responsible for the arrangement of the program for the annual dinner of the Society.

COMMITTEE ON POSTGRADUATE EDUCATION

Article X, Section 3, Par. 2 of the By-Laws of the Society provides:

The Nominating Committee shall appoint to the House of Delegates each year a Committee on Postgraduate Education of not less than seven members and name its chairman. The purpose of the Committee shall be to plan and make available programs of postgraduate education for members of the Society, to arrange and conduct the annual Clinical Congress of the Society, and to cooperate with University and other agencies within the State for the extension of postgraduate education of physicians.

EDITORIAL BOARD OF THE JOURNAL

Article X, Section 3, Par. 3 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates each year an Editorial Board of the JOURNAL, consisting of not more than fifteen members. One of these shall be nominated as the Managing Editor of the JOURNAL and he shall be a member of the Council also. One other member of the Board shall be nominated as Literary Editor of the JOURNAL and he shall serve as Chairman of the Edi-

torial Board. The Literary Editor, with the active participation and advice of other members of the Board, shall be responsible for the acceptance or rejection of manuscripts for publication and for their literary quality. He shall not be concerned with the business or financial aspects of the JOURNAL, which shall be the responsibility of the Managing Editor. The remaining members of the Editorial Board, shall be selected so far as feasible, to represent the major division of medicine, surgery, pediatrics, obstetrics and psychiatry and consideration shall be given to representation from the geographic areas of the State. In addition to the Board so nominated, the President of the Society shall serve as an ex officio member with all rights and privileges of other members during the term of his office. The Editorial Board shall edit and publish the CONNECTICUT STATE MEDICAL JOURNAL and shall determine its advertising policy, all in a manner to promote the best interests of medicine.

COMMITTEE ON HONORARY MEMBERS AND DEGREES

Article X, Section 3, Par. 4 of the By-Laws of the Society provides:

The Committee on Honorary Members and Degrees shall consist of the three latest Past Presidents of the Society. This Committee may present annually to the House of Delegates the names of not more than three eminent physicians as candidates for honorary membership in the Society. The Committee may recommend the bestowal of an honorary degree in medicine upon any person not a physician, distinguished in the sciences of medicine or for contribution in human welfare.

COMMITTEE ON HOSPITALS

Article X, Section 3, Par. 5 of the By-Laws of the Society provides:

The Nominating Committee shall nominate annually to the House of Delegates, a Committee on Hospitals to consist of not less than six members, and shall nominate the chairman thereof. This Committee shall pursue the continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this State and shall, when indicated, confer with the State Department of Health and representatives of the Connecticut Hospital Association and make recommendations to the Society.

COMMITTEE ON INDUSTRIAL HEALTH

Article X, Section 3, Par. 6 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House

of Delegates annually a Committee on Industrial Health to consist of not less than ten members, and nominate the chairman thereof. The function of this Committee shall be to inquire into health in industry for the purpose of making the information on the subject available to the members of the Society and all other persons interested in improving health and hygiene of persons employed in industry.

COMMITTEE ON MEDICAL EDUCATION AND LICENSURE

Article X, Section 3, Par. 7 of the By-Laws of the Society provides:

At each annual meeting the Nominating Committee shall nominate to the House of Delegates a member of the Society to be proposed to the Governor of the State of Connecticut for appointment as a member of the Connecticut Medical Examining Board for a term of five years in accordance with Section 2748 of the General Statutes of 1930 as amended. During the month of December of each year the Executive Secretary of the Society shall prepare a statement informing the Governor of the Society's choice of a member to be appointed as a member of the Connecticut Medical Examining Board, and, after obtaining the signature of the President of the Society on this statement, it shall be delivered to the Governor. In the event of a vacancy on the Connecticut Medical Examining Board and when it is not practicable to have the choice of another member of the Society who is to be recommended to the Governor for appointment made by the House of Delegates, the President shall propose to the Governor a member of the Society for appointment. The Connecticut Medical Examining Board shall constitute the Society's Committee on Medical Education and Licensure and the President of that Board as elected by its members shall be the Chairman of the Society's Committee. The function of the Committee on Medical Education and Licensure shall be to study the educational and legal requirements for practitioners of medicine in the State of Connecticut, to provide information for the members of the Society on these and related subjects, and, as occasion arises, to recommend to the Society amendments to the statutes regulating the practice of medicine within this State and the maintenance of a high quality of medical care in Connecticut.

PROGRAM COMMITTEE

Article X, Section 3, Par. 8 of the By-Laws of the Society provides:

The Program Committee shall consist of three members, one member of which shall be nominated annually by the Nominating Committee for election by the House of Delegates for a term of three years. The chairman of the Committee shall be the member who is serving the final year of his term of office. The duties of this Committee shall be to arrange a scientific program for the meetings of the Society and it shall prepare such program for the annual meeting and submit it to the Executive Secretary of the Society for publication not less than two months preceding the date of the meeting.

COMMITTEE ON PUBLIC HEALTH

Article X, Section 3, Par. 9 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House

of Delegates annually one member from each component county association and such additional members as it may determine, not to exceed fifteen to be the Committee on Public Health and nominate the Chairman thereof. The Committee on Public Health shall be the representative of the Society in all matters pertaining to public health, sanitation, the prevention of contagious diseases, maternal and infant welfare. It shall confer from time to time with the Connecticut State Health Department and other legal public health authorities in a manner mutually agreeable, and it shall inform the Society concerning matters of public health and, as occasion arises, recommend for the Society's consideration, desirable legal enactments to promote public health within the State.

COMMITTEE ON STATE LEGISLATION

Article X, Section 3, Par. 10 of the By-Laws of the Society provides:

Before the 15th of January of each year, the secretary of each county association, acting on behalf of the association, shall forward to the Executive Secretary of the Society, the name of a member of the county association who is recommended to the Nominating Committee for nomination as a member of the Committee on State Legislation. In addition to these eight members, the Committee shall include the Delegates to the American Medical Association and the Executive Secretary who shall serve as the executive officer of the Committee. The Chairman of the Committee shall be designated by the Nominating Committee. The function of this Committee shall be to review and advise the members of the Society concerning proposed State legislation pertaining to the public health, welfare and the practice of medicine. The Committee shall, as occasion arises, draft and have introduced into the General Assembly of this State, appropriate legislation for improving medical care and the public health within the State, advise the Society's legislative agent concerning the opinion of the Society on pending legislation, and supervise and direct the Society's program in the State legislative field.

COMMITTEE ON PUBLIC RELATIONS

Article X, Section 3, Par. 11 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Committee on Public Relations to consist of eight members, and nominate the Chairman thereof. The function of this Committee shall be to inquire into and pass upon such phases of public information as deal with the care of the sick and the practice of medicine, and shall endeavor to keep the people of Connecticut accurately and reliably informed concerning matters of public interest in the field of medicine. The Committee shall use its efforts to encourage cordial relations and understanding with the public press and radio, and cooperate with other committees of the Society in a program of public relations.

CANCER COORDINATING COMMITTEE

Article X, Section 3, Par. 12 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Cancer Coordinating Committee.

The membership of this Committee shall be not less than seven and not more than nine members and shall at all times include the President of the Connecticut Cancer Society, the Chairman of the Connecticut Association of Tumor Clinics and a representative of the State Department of Health. The purpose of this Committee shall be to coordinate and integrate the efforts of the various agencies concerned with the study, prevention and treatment of cancer in Connecticut.

COMMITTEE ON PROFESSIONAL RELATIONS

Article X, Section 3, Par. 13 of the By-Laws of the Society provides:

At its semi-annual meeting in 1950, each component county association shall elect a past president of the Association to serve on a State Committee on Professional Relations. The members so elected from the associations in the counties of Hartford, New London, Windham and Middlesex shall serve until the annual meeting of these associations in 1951, at which time the Hartford, New London, Windham and Middlesex county associations shall elect a past president to serve on the State Committee on Professional Relations for a period of two years, and such election shall be biannually thereafter. The members so elected from the associations in the counties of New Haven, Fairfield, Litchfield and Tolland shall serve until the annual meeting of these county associations in 1952, at which time the New Haven, Fairfield, Litchfield and Tolland county associations shall elect a past president to serve on the State Committee on Professional Relations for a period of two years and such election shall be held bi-annually thereafter.

No member shall be elected to serve two consecutive terms of two years each, but this restriction shall not apply to the members elected originally at the semi-annual meetings of 1950. No member of the Society who is an elected officer or a member of the Council of the State Medical Society shall be eligible for election to this Committee.

The Committee shall elect its own chairman and recorder and all sessions of the Committee shall be executive sessions and not attended by others except by invitation of the Committee.

This Committee shall have no jurisdiction in legal actions relating to professional malpractice or negligence. The purposes of the Committee shall be (1) to hear complaints and charges against members of the Society referred to it by county medical associations and (2) to hear appeals from decisions on charges reached by county medical associations or boards of censors of county medical associations.

When charges against members of the Society are received by the Society Secretary, either from the public or other physicians, they will be referred at once to the Secretary of the county association of which the physician complained against is a member and original jurisdiction in the complaint shall lie with the county association. If in the judgment of the appropriate Committee in the county association, the complaint should be heard by the State Committee on Professional Relations, it shall refer the complaint to that Committee. The member of the Committee representing the county association to which a physician against whom charges have been brought belongs shall not vote on the final conclusion reached by the Committee.

After a hearing during which the complainant and the physician against whom written charges have been brought shall be given an opportunity to appear, the Committee by ballot shall exonerate or impose such disciplinary action as it may deem appropriate and these disciplinary actions may include reprimand, suspension or termination of membership in the Society. The Committee, upon arriving at a decision, shall notify the physician against whom charges have been brought of its findings and disciplinary action to be taken, and at the same time, file a resume of its findings and action with the secretary of the County Association to which the physician belongs and with the Council of the State Medical Society. A member disciplined by the action of the Committee shall have the right of appeal to the Council before the expiration of fifteen days from the receipt of the Committee's findings. In the absence of such appeal, the action of the Committee is final.

COMMITTEE ON MENTAL HEALTH

Article X, Section 3, Par. 14 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Committee on Mental Health to consist of not more than eight members and nominate the chairman thereof. The Committee shall be continuously informed concerning the provisions for the care of the mentally ill in the State and those addicted to the use of habit-forming drugs and alcohol with the purpose of making information on these subjects available to the members of the Society and, if indicated, to recommend and support legislation for the improvement of the care of persons in this State so afflicted.

COMMITTEE ON THIRD PARTY PAYMENTS

Article X, Section 3, Par. 15 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Committee on Third Party Payments to consist of five members and nominate the chairman thereof. The function of this Committee shall be to study existing and projected systems providing payment for physicians' services by any public, private, or cooperative agency, and to advise the Society concerning them. In its operations, the Committee shall confer with representatives of such agencies and other committees of the Society having interest and responsibility in specific phases of medical care that involve payment of physicians by third party agencies.

COMMITTEES APPOINTED BY THE COUNCIL (not requiring election by the House of Delegates)

COMMITTEE ON COOPERATION WITH THE YALE SCHOOL OF MEDICINE

The purpose of this committee is to continue and strengthen the historic close relationship between the Connecticut State Medical Society and the Yale University School of Medicine and to further the effectiveness of undergraduate and graduate programs of medical education.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The purpose of this committee is to serve in an advisory capacity to the Woman's Auxiliary of the State Medical

Society in matters of general policy, insofar as they relate to the program of the State Medical Society and upon request, to confer with the Auxiliary in the development of this program.

CONFERENCE COMMITTEE WITH CONNECTICUT PHARMACEUTICAL ASSOCIATION

The purpose of this committee is to provide a continuing conference group between the Connecticut State Medical Society and the Connecticut Pharmaceutical Association for the study and integration of the purposes and objectives of the common problems of the professions of medicine and pharmacy in Connecticut.

COMMITTEE ON NATIONAL LEGISLATION

The purpose of this committee is to be informed constantly concerning proposed national legislation relating to medical care and welfare. The committee shall advise the Council on details of proposed legislation in the fields of health and welfare and express its opinion, with appropriate approval, to Connecticut Representatives and Senators in the Congress of the United States. The Committee shall endeavor to keep members of the State Medical Society informed on trends and developments in national legislation that may be expected to affect medical service.

COMMITTEE ON STATEWIDE BLOOD BANK

The purpose of this committee is to promote the development of a statewide blood bank operating in the interests of the people and the medical profession. The committee is authorized, in the name of the Society, to cooperate with responsible agencies such as the American Red Cross, the State Department of Health, in prescribing professional policies of the operation of a blood bank.

COMMITTEE ON MEDICAL CARE OF VETERANS

The purpose of this committee is to cooperate with the Medical Section of the U. S. Veterans Administration and to represent the medical profession in Connecticut in all negotiations concerning the medical care of veterans, the payment for such care, and matters of general medical policy.

COMMITTEE ON RURAL MEDICAL SERVICE

The purpose of this committee is to develop a program of medical service for the rural population of Connecticut in cooperation with the Council on Rural Medical Service of the AMA.

ADVISORY COMMITTEE TO THE STATE BOARD OF EXAMINERS FOR NURSING

The purpose of this committee is, upon request, to cooperate and advise with the State Board of Examiners for Nursing in matters of general policy.

MEDICAL ADVISORY COMMITTEE TO THE JOINT COMMISSIONS

This committee shall serve in a medical advisory capacity to the Veterans Home and Hospital Commission, and the Commission on the Care and Treatment of the Chronically Ill, Aged, and Infirm.

COMMITTEE TO STUDY MATERNAL MORTALITY AND MORBIDITY

The purpose of this committee is to study maternal mortality and morbidity in Connecticut with the purpose of

making their best contribution toward lowering the maternal and morbidity rate from these causes.

ADVISORY COMMITTEE TO THE PUBLIC WELFARE DEPARTMENT

This committee was appointed, at the request of the Commissioner of Public Welfare of the State of Connecticut, to advise with him and the Medical Director of the Public Welfare Commission in all matters concerning medical care and hospitalization and to endeavor to maintain cooperation between the Commission of Welfare and the medical profession of the State.

CONFERENCE COMMITTEE FOR THE IMPROVEMENT OF THE CARE OF THE PATIENT

This is a joint committee, consisting of representatives from the State Medical Society, the State Nurses' Association, and the State Hospital Association. Its purpose is to study problems of mutual interest to the medical, nursing and hospital administrative professions with a view to finding solutions to problems involving improvement of the care of hospital patients.

COMMITTEE ON EMERGENCY MEDICAL SERVICE

The purpose of this committee is to integrate the planning and purposes of the medical profession with the Connecticut State Defense Council and to cooperate with the Council on Emergency Medical Service of the American Medical Association.

CONFERENCE COMMITTEE WITH THE CONNECTICUT STATE DENTAL ASSOCIATION

This committee is appointed to be the conference group with the State Dental Association and to discuss with that group problems of mutual interest to the two professions and bring the professions into closer relationship in all fields.

COMMITTEE ON BUILDING MANAGEMENT

The purpose of this committee is to supervise the operation of the Society's headquarters building, including all details of its financing.

BOARD OF DIRECTORS, CONNECTICUT MEDICAL SERVICE

The By-Laws of Connecticut Medical Service provide that six members of the Board of Directors of that Corporation shall be appointed by the Council of the Connecticut State Medical Society. Although this group is actually not a committee of the Society, the six members so appointed have an important purpose. That purpose is to integrate the purposes and objectives of the medical profession with the operation of Connecticut Medical Service and to keep the medical profession of Connecticut informed concerning developments in the field of prepaid medical service.

COMMITTEE TO STUDY NEONATAL MORTALITY

The purpose of this committee is to inquire into the causes of neonatal mortality in Connecticut with the object of making suggestions for the removal of the causes of neonatal mortality.

CONFERENCE COMMITTEE WITH AMERICAN LEGION DEPARTMENT OF CONNECTICUT

The purpose of this committee is to confer with a similar committee from the American Legion Department of Connecticut on matters of mutual and public interest.

CONFERENCE COMMITTEE WITH THE CONNECTICUT BAR
ASSOCIATION

The purpose of this committee is to confer from time to time with representatives of the Connecticut Bar Association on matters of mutual interest to the medical and legal professions.

Meetings Held in June

- June 5—Committee on State Legislation
- June 8—Committee to Study Neonatal Mortality
- June 9—Committee on Public Health
- June 10—Clinical Congress Conference
- June 14—Public Relations Committee
- Dental Conference Committee
- Medical Advisory Committee, Connecticut Cancer Society
- June 15—Connecticut Medical Examining Board
- June 16—Subcommittee on School Health
- June 20—Conference on State Hospitalization
- June 22—Committee on Maternal Mortality and Morbidity
- June 23—Council

Friend Lee Mickle Honored by Connecticut Public Health Association

Friend Lee Mickle, M.S., S.C.D., (left) is shown receiving the first C.-E. A. Winslow Award of the Connecticut Public Health Association from Dr. Leonard Parente, M.D., M.P.H., chairman of the Award Committee.

The presentation took place at the annual meeting of the association, held May 18 at Cedarcrest Sanatorium, Newington.

The award was established by the membership of C.P.H.A. in 1954 to honor a Connecticut person who has made an outstanding contribution to public health in the State.

Formerly director of the Bureau of Laboratories, Connecticut State Department of Health, Dr. Mickle has long been active in State and national public health activities.

In presenting the award to Dr. Mickle, the following citation was read by Dr. Parente:

"He is a man who has served the State of Con-



necticut faithfully and continuously for the last quarter of a century. He has developed our State laboratory so that today it is well recognized for its excellent work. He has built up services of a high standard for diagnosis and for environmental control, reaching a very large proportion of the people of the State. Similarly his high standard of service has had nationwide influence, especially as vice chairman and chairman of the Laboratory Section of the Coordinating Committee of Standard Methods of the APHA. He has also been cited in recognition of outstanding service in the field of dairy manufacturing and to collegiate training in the State of Connecticut. He was vice president of the APHA and president of the CPHA 1952-53 and president of the Connecticut Association of Milk and Food Sanitarians 1953-54. He is a member of several scientific organizations and author of numerous scientific publications. He is a man of skill, industry, integrity, diplomacy and unselfishness.

"May I present to you, Dr. Friend Lee Mickle, the 1955 C.-E. A. Winslow Award of the CPHA."

Dr. William G. H. Dobbs Elected President of Society's Section on Radiology

William G. H. Dobbs, Torrington, was recently elected president of the Section on Radiology, Connecticut State Medical Society. He succeeds Willard Buckley of Middletown.

William A. Goodrich of Hartford, was elected vice president of the Section and John Burbank, Meriden, was elected secretary.

The Subpoena of Hospital Records — Public Act 89, 1955

Senate bill 576, designed to make hospital records available in court without the attendance of hospital personnel, became Public Act 89 in June. The bill, introduced by Senator Theodore Ryan, president of Sharon Hospital, in cooperation with the CHA's Council on Government Relations, becomes effective on October 1, 1955 and in content revises Section 294 of the General Statutes. A copy of the new laws appears below.

Attention is called to several provisions of special significance:

Patient, after discharge, may see own record on demand.

The records of mentally ill patients are not covered.

Hospitals have the option to submit certified copies instead of the original record.

Clerk of the court must give receipt for the record, be responsible for its safekeeping, and notify the hospital when no longer needed.

Record can be admitted in evidence without preliminary testimony providing affidavit from person in charge of record room is attached.

Subpoena must be served or written notice of intent to serve given not less than twenty-four hours before the time of production.

CHA Counsel John Q. Tilson, Jr., of Wiggin & Dana, who wrote the legislation, is preparing a suitable certification form for use when records are transmitted under the new law. This will be released when ready. In the meantime, CHA members can rejoice that one troublesome and costly problem of the Medical Records Department is approaching solution.

State of Connecticut

General Assembly

January Session, 1955

Public Act No. 89

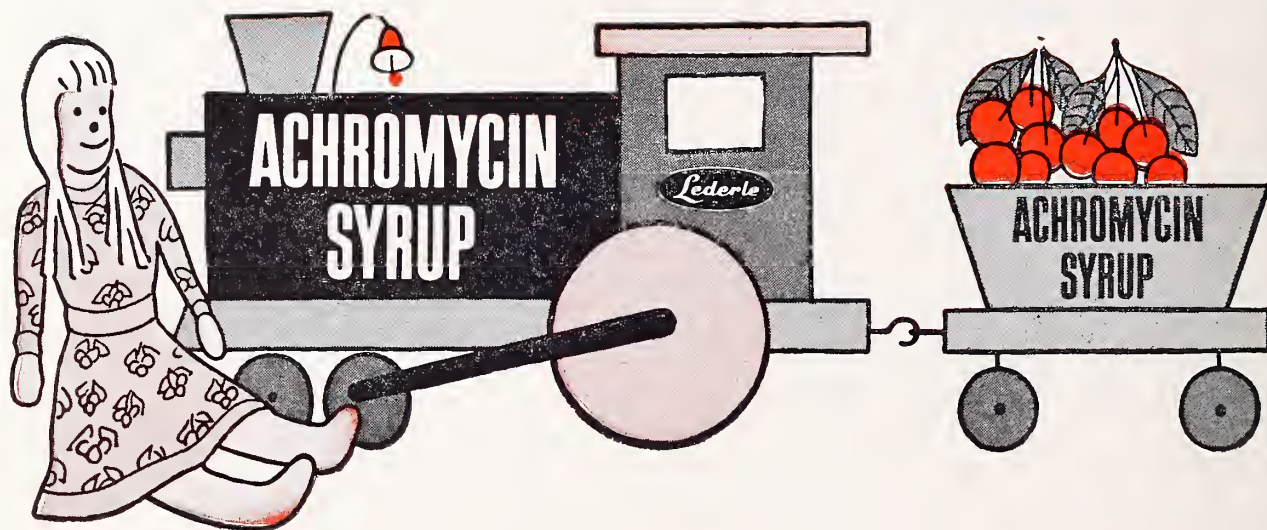
An Act Concerning Subpoena of Hospital Records

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 294 of the general statutes is repealed and the following is substituted in lieu thereof: Each private hospital, public hospital society or corporation receiving State aid shall, upon the demand of any patient who has been treated in such hos-

pital and after his discharge therefrom, permit such patient or his physician or duly authorized attorney to examine the hospital record, including the history, bedside notes, charts, pictures and plates kept in connection with the treatment of such patient, and permit copies of such history, bedside notes and charts to be made by such patient, his physician or duly authorized attorney. If any such hospital, society or corporation is served with a subpoena issued by competent authority directing the production of such hospital record in connection with any proceedings in any court, the hospital, society or corporation upon which such subpoena is served may, except where such record pertains to a mentally ill patient, deliver such record or at its option a copy thereof to the clerk of such court. Such clerk shall give a receipt for the same, shall be responsible for the safekeeping thereof, shall not permit the same to be removed from the premises of the court and shall notify the hospital to call for the same when it is no longer needed for use in court. Any such record or copy so delivered to such clerk shall be sealed in an envelope which shall indicate the name of the patient, the name of the attorney subpoenaing the same and the title of the case referred to in the subpoena. No such record or copy shall be open to inspection by any person except upon the order of a judge of the court concerned, and any such record or copy shall at all times be subject to the order of such judge. Any and all parts of any such record or copy, if not otherwise inadmissible, shall be admitted in evidence without any preliminary testimony, if there is attached thereto the certification in affidavit form of the person in charge of the record room of the hospital or his authorized assistant indicating that such record or copy is the original record or a copy thereof, made in the regular course of the business of the hospital and that it was the regular course of such business to make such record at the time of the transactions, occurrences or events recorded therein or within a reasonable time thereafter. A subpoena directing the production of such hospital record shall be served not less than twenty-four hours before the time for production, provided such subpoena shall be valid if served less than twenty-four hours before the time of production if written notice of intent to serve such subpoena has been delivered to the person in charge of the record room of such hospital not less than twenty-four hours nor more than two weeks before such time for production.

PLEASANT CHERRY FLAVOR!
125 MG. PER 5 CC. TEASPOONFUL! NO REFRIGERATION!
AQUEOUS—NO OIL,



ACHROMYCIN^{*}

HYDROCHLORIDE
TETRACYCLINE HCl *Lederle*

OTHER FORMS OF ACHROMYCIN FOR PEDIATRIC USE:

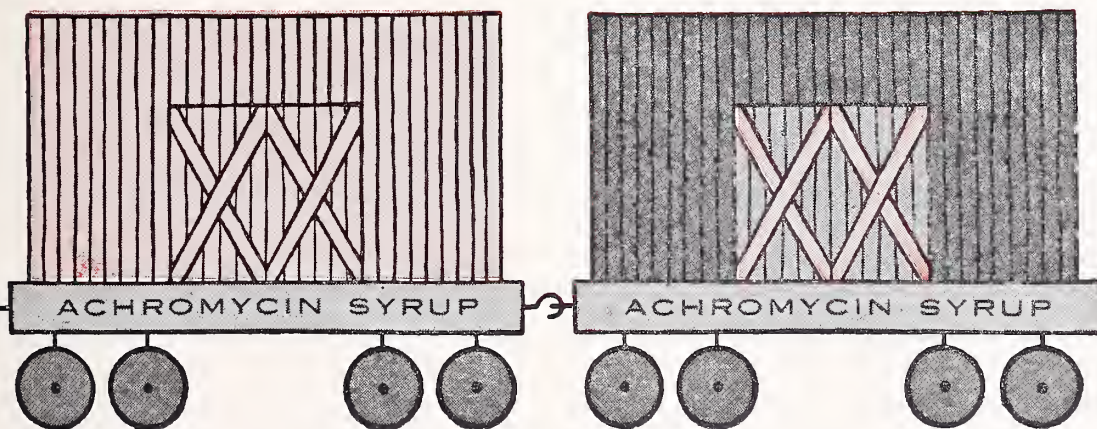
PEDIATRIC DROPS (Cherry Flavor): 100 mg. per cc. (approx. 5 mg. per drop)

ORAL SUSPENSION (Cherry Flavor): 250 mg. per teaspoonful (5 cc.)

SPERSOIDS* Dispersible Powder (Chocolate Flavor): 50 mg. per rounded teaspoonful (3 Gm.)

READY TO USE! IN 2 OZ. BOTTLES!

NO AFTERTASTE! MISCIBLE WITH WATER, MILK, SODA!



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ACHROMYCIN • broad-spectrum • rapid diffusion • prompt control of infection • well tolerated • effective against Gram-positive and Gram-negative bacteria, rickettsiae, and certain viruses and protozoa.

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THE HISTORIAN'S NOTE BOOK

THE GREAT SICKNESS IN HOLLISTON

Referred to by Noah Webster

ARTHUR S. BRACKETT, M.D.

EVERYONE knows about Dr. Salk's work to combat epidemics of poliomyelitis. But few know who was the first epidemiologist in the United States. He was Noah Webster, who was born in West Hartford, Connecticut in 1758 and who died in New Haven, Connecticut in 1843. In 1778 he was graduated from Yale and in 1795 from Princeton.

Though best known for his "Spelling Book" (1783-5), "A Compendious Dictionary of the English Language" (1806), and "American Dictionary of the English Language" (1828), this versatile man was admitted to the bar in 1781, and became a journalist in New York in 1788, writing on many subjects. In 1796 he published "A Collection of Papers on the Subject of Bilious Fevers Prevalent in the United States for a Few Years Past."

In 1799 a two-volume work called "A Brief History of Epidemic and Pestilential Diseases" came out.¹ Webster may have considered it a "Brief History," but on account of its length and the small type used I gave it up after reading one volume and a half. Among the many epidemics he mentions briefly is one about the great sickness in Holliston.

This same epidemic is vividly described in Barber's "Massachusetts Historical Collections" as follows: "December, 1753, and January, 1754, were remarkable for what is called the great sickness in Holliston. 'The patients were violently seized with a piercing pain in the breast or side; to be seized with a pain in the head was not common' [in other words this happened sometimes] 'the fever high. The greater part of those that died were rational to the last; they lived three, four, five, and six days after they were taken. In some instances, it appears, they strangled, by not being able to expectorate; some in this case, who were thought to be in their last moments, were recovered by administering oil. In about six weeks fifty-three persons died, forty-one of whom died within twenty-two days.' The following account of this sickness is extracted from the

account kept by the Rev. Mr. Prentiss. 'December 31st, seven lay unburied. January 4th, ten lay unburied, in which week seventeen died. There were two, three, four, and five buried for many days successively. Of those who died, fifteen were members of this church.' 'We are extremely weakened by the desolation death has made in many of the most substantial families among us; four families wholly broken up, losing both their heads. The sickness was so prevalent, that but few families escaped; for more than a month, there was not enough well to tend the sick and bury the dead, though they spent their whole time in these services; but the sick suffered and the dead lay unburied; and that, notwithstanding help was procured, and charitable assistance afforded, by many in the neighboring towns.' 'We are a small town, consisting of about eighty families, and not more than four hundred souls.'"²

After I read the above, it seemed to me it was not likely that the sickness could have been confined to one town only. Then I remembered that as a young boy, while visiting my grandfather in Framingham, Massachusetts I had read in Temple's "History of Framingham" about the great sickness in Holliston. On rereading Temple, I found that he refers to this epidemic as taking place in three towns. It "broke out in Holliston about the middle of December." "The number of deaths in Sherborn [a neighboring town] was between twenty and thirty." He describes what happened in Framingham: "1754. The first four months of this year are made memorable by the prevalence of a fatal distemper known as the 'great sickness.' The town records notice the death of seven persons as victims of the disease; but it is nearly certain that other deaths occurred, which were not recorded. The Goddard family . . . and the families living north of the Mountain, appear to have been the greatest sufferers. Rev. David Goddard, minister, of Leicester, while on a

visit here, was taken down, and died Jan. 19. His mother died Feb. 4, and his father, the Hon. Edward Goddard, died Feb. 9. Others of the family were sick but recovered. Joshua Hemenway, Jr., died Jan. 30."³

It is hard to make a diagnosis of the "great sickness." The strangling referred to seems like diphtheria, which we know was endemic in Eastern Massachusetts at that time.⁴ The pain in the side might indicate pleurisy. Perhaps the great sickness was a combination of both diphtheria and pleurisy, plus one or more unknown factors. Whatever it was, it was most malignant and contagious.

REFERENCES

1. Aesculapius Comes to The Colonies—Maurice Bear Gordon, M.D. Ventnor Publishers, Inc. Ventnor, N. J. c. 1949 pp. 15, 159, 160.
2. Massachusetts Historical Collections—John A. Barber. Pub. about 1840.
3. History of Framingham, Massachusetts—J. H. Temple. Pub. by the Town of Framingham—1887, p. 220.
4. A Compendious History of New England—Jedidiah Morse, D.D. and Elijah Parish, D.D. Pub. by Thomas and Whipple, Newburyport, 1809, pp. 308-310 inclusive.

New Liaison Committee With Labor and Management

AMA Board Chairman Dwight H. Murray has announced appointment of a committee to meet with representatives of labor and management in a joint effort to understand and help solve some of the medical problems that are associated with working people.

The committee, headed by President-Elect Elmer Hess, was appointed as an outgrowth of an idea advanced by President Walter H. Martin when he spoke recently at the annual Congress on Industrial Health in Washington. Dr. Martin said that labor, industry, and medicine were in practical agreement on many health objectives and that better liaison could and should be created among the interested groups to solve some of the medical problems in that area.

A. J. Hayes, Washington, D. C., vice president of the American Federation of Labor, speaking at this same meeting, considered the idea a good one. Mr. Hayes' union publication gave considerable prominence to Dr. Martin's remarks as well as his own.

Physicians Wanted For National Guard

The attention of all physicians, including interns and residents, is invited to the fact that several vacancies exist in the National Guard and Air National Guard of Connecticut, for medical officers. Doctors presently commissioned in the Reserve can be appointed in their current reserve grade and then promoted when sufficient time in grade has elapsed and there is a position vacancy for a higher rank. Doctors not now connected with the military may be appointed in a grade based on their age and years of professional experience. Membership in the National Guard entitles doctors to payment for drills performed, and provision is made for a yearly uniform allowance. All officers are entitled to retirement or elected annuity benefits. This is an opportunity for doctors to participate in the National Defense Program while in a civilian status. Those interested are requested to write to The Adjutant General, State Armory, Hartford, Connecticut.

Dr. Carl M. Peterson, secretary of the AMA Council on Industrial Health, said "This new committee is intended to supplement the work of various agencies in the AMA which have devoted much time and effort to consideration of industrial health, industrial hygiene, workmen's compensation, rehabilitation, and union health and welfare programs, all of which will be continued."

"There are many widely divergent points of view on medical care," Dr. Hess said, "but there are many areas, particularly in the field of preventive medicine, where the time is ripe for realistic discussion of the issues. This committee offers great possibilities for determining whether attitudes on many of the vexing health problems are irreconcilable or offer a genuine opportunity for mutually helpful activity."

Besides Dr. Hess, the committee is composed of: Drs. James R. McVay, Kansas City, a member of the Board of Trustees; Joseph D. McCarthy, Omaha, chairman of the Council on Medical Service, and William P. Shepard, New York, chairman of the Council on Industrial Health.

Special Article

THE AGED IN THE STATE HOSPITALS

PRACTICING physicians in Connecticut recently received a Newsletter from the Department of Mental Health which described the aged in the mental hospitals as "one of the most critical problems facing the people of Connecticut." In the Newsletter the Commissioner of Mental Health relates that "many of these older folks who were certified as needing psychiatric care and treatment were also suffering from organic ailments of an equal or greater severity than the disorder which made possible their commitment," and then asks "Is psychiatry best endowed to provide the most effective treatment . . . ?"

We are compelled to observe that the Department of Mental Health seems to be in the throes of inconsistencies regarding the weighty problems which are its responsibilities, and it seems appropriate to discuss some of these at this time. We would not have been surprised by the contents of this Newsletter had it been published a year ago, but in the light of studies recently completed by the Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm in cooperation with the Department of Mental Health the implications seem to be somewhat at variance with facts.

We have long heard that aged persons are sent to mental hospitals unnecessarily and although each of us in our experience felt that we had not certified needless commitments, we remained silent because we could not answer for our confreres. The recent studies corroborate our own beliefs that physicians have not acted inappropriately in committing patients to the mental hospitals. In spite of this we are still faced with statements to the contrary, and with current legislative proposals to change the commitment procedures. These latter are based on the contention that practicing physicians cannot be trusted to exercise honest judgment as to their patients' need for mental hospitalization.

We are constantly bombarded with admonitions to consider mental illness as we do physical illness, without prejudice and without stigma, and at the same time we are told that the aged who have mental illness shouldn't be in mental hospitals. It is a

fact that 40 per cent of persons in our State mental hospitals are 60 years of age and over, but not until the findings of the recent study were made available was it noted that the vast majority of these are persons admitted for functional psychoses when younger, who have grown old in the mental hospitals.

We know that new admissions to the mental hospitals of persons 60 years of age and older are increasing, but cannot accept implications that this is bad. We can only be gratified that our efforts in interpreting to families that mental illness can and should be treated in mental hospitals have begun to be successful. We are not surprised that the study recently reported showed a significant number of the new admissions over 60 years of age to have functional psychoses. We feel that general acceptance of the fact that the mere attaining of age 60 by a mentally ill person doesn't convert him to a simple "senile," any more than attaining of age 60 by a normal person makes him "senile," is overdue.

The most recent contention of our Mental Health Commissioner is that the presence of concomitant physical illness on the part of an older mentally ill person makes it inappropriate for a mental hospital to care for the patient. This is stated in spite of the fact that much attention is given to the axiom of total medical care, and in spite of the fact that the recent studies indicate that over 60 per cent of those older patients admitted to the mental hospitals came from either general hospitals or chronic and convalescent hospitals, indicating the inability of these facilities to handle the psychiatric problems involved. Our mental hospitals have never hesitated to provide complete medical and surgical care to their younger patients. Why is now the question raised with regard to their older patients?

We cannot deny our State mental hospitals are crowded, but we must point out that we rank high in the nation in mental hospital beds in relation to population. We take pride in the fact that our State mental hospitals are all among the very few approved by the national certification groups. We submit simply that an injustice is being done to the

mental health cause by statements to the effect that some mentally ill persons should be denied psychiatric supervision as the means of relieving crowding.

We can all share the disappointment of our State officials when the recently obtained data showed that simply removing elderly people from the mental institutions is no ready solution to crowding. We cannot, however, share their contention that there must be another way of handling those mentally ill persons who have either poor psychiatric prognoses or concomitant physical illness. We have already as a profession been criticized for overspecialization. Here, we feel, is an instance where a specialty has a clear-cut responsibility which it should assume rather than seeking "another medical discipline, perhaps one not yet fully defined."

There is also a tendency to consider that our problems are somehow different. This compels us to quote from a publication of The Council of State Governments, "The Mental Health Programs of the Forty-Eight States, A Report to the Governor's Conference, 1950." This report lists the following as factors contributing to the growth in mental hospital population:

"1. The general population has grown. There are simply more people who could have a mental disease.

"2. There are more people in the older age brackets, where the highest incidence of mental disease has always fallen.

"3. More hospital accommodations are available for care and treatment of mental patients. In the past, additional accommodations have always meant additional patients because the need for accommodations has been so great.

"4. Both the medical profession and the general public know more about mental disease, and have been increasingly willing to utilize mental hospitals. Confidence in the hospitals has grown.

"5. The concept of mental disturbance has broadened. Formerly, only the severest types of mental illness were considered for hospitalization, but patients are now drawn from a wider and wider range of disturbed conditions.

"6. People live longer, not only in the community but in the hospital. They have a greater average

duration of hospital life, partly because of improved standards of general accommodation and care that prolong life itself. Some patients, too, remain longer in the hospital because of higher standards of psychiatric care, because of the inability or unwillingness of the community to find places for them, or because of the shortage of social workers for aftercare.

"7. Urbanization of society is doubtless a factor. Many mentally erratic or disturbed persons, who might be cared for quite well in a farm or small-town environment, may be both helpless and difficult in a crowded urban center. Mentally ill persons, especially the aged and senile, are all too often an unbearable burden in a city apartment. Moreover, the rushing tempo of urban life today is a far cry from the typical living conditions of a century ago. This may act to produce more disturbed people; it does act to make it more difficult for the disturbed person to get along in the world outside the hospital."

While we endorse the aims of the Department of Mental Health to better staff their institutions and utilize other resources for care of their normal discharge backlog, we must observe that a frontal attack in terms of more facilities for the mentally ill of all ages seems to be the only reasonable approach to future planning.

Dr. Harold Lipton New Surgeon General

Harold Lipton of Hartford has become surgeon general of Connecticut. Dr. Lipton, a lieutenant colonel, is senior medical officer of the Connecticut Air National Guard and Connecticut National Guard. He replaces Lt. Col. Joseph Sokal who resigned as surgeon general and from the guard March 31 to take up research duties at Buffalo, N. Y. A pediatrician, Dr. Lipton is former chief of pediatrics at the Danbury Hospital. During the war he was a flight surgeon in the Army Air Force. He saw duty in the Far East, receiving five battle stars and a presidential citation. His appointment as surgeon general became effective April 1 under a State statute which automatically names the senior medical officer of the National Guard to the post.

SAVE THESE DATES: NOVEMBER 29 - DECEMBER 2

AMA CLINICAL SESSION — BOSTON

AMA — ATLANTIC CITY — JUNE 6-10, 1955

Connecticut Physicians Attending 104th Annual Meeting

Thomas P. Murdock, Meriden, Board of Trustees.
Stanley H. Osborn, Hartford, Council on Constitution and By-Laws.

Thomas J. Danaher, Torrington, House of Delegates, member Reference Committee on Hygiene and Public Health.

John N. Gallivan, East Hartford, House of Delegates.

Stanley B. Weld, Hartford, House of Delegates.

Ralph M. Tovell, Hartford, Scientific Program.

Francis J. Braceland, Hartford, chairman, Section on Nervous and Mental Diseases.

Oliver L. Stringfield, Stamford, Executive Committee, Section on Pediatrics.

Thomas F. Hines, New Haven, Scientific Program.

William W. Zeller, Hartford, Scientific Program.

Walter F. Jennings, Hartford, Demonstrator, Fracture Exhibit.

J. Whitfield Larrabee, Hartford, Demonstrator, Fracture Exhibit.

Stuart C. Finch, New Haven, Scientific Exhibit.

Edward Scull, Hartford, Scientific Exhibit.

Joseph M. Adzina, Bridgeport
H. Everett Allen, Waterbury
Charles A. Audet, Sr., Waterbury
Charles H. Audet, Jr., Waterbury
W. H. Baldwin, Manchester
Paul H. Barbour, Farmington
Creighton Barker, New Haven
Roy Barnett, Norwalk
Carl Bausch, Hartford
Eugene C. Beck, Norwalk
Donald M. Beckwith, East Haven
Hazel Berglund, Greenwich
Dwight J. Bernstein, New Britain
Edward J. Blumenthal, Ansonia
Francis D. T. Bowen, Hartford
S. H. Bowman, Stamford
William R. Bradley, Hartford
Francis S. Buccheri, New Britain
Alfred L. Burgdorf, Bloomfield
J. S. Burkle, New London
Benson, Calef, Farmington
Robert M. Carpenter, Stamford
Gray Carter, Greenwich
Edward V. Carvey, Wethersfield
L. E. Celentano, New Haven
G. M. Chartier, Danielson
H. M. Chernoff, New Haven
L. A. Chotkowski, Kensington
Clement C. Clarke, New Haven
David H. Clement, New Haven
Martha L. Clifford, Hartford
David F. Conway, Jr., New Haven
Mark Coral, Terryville
Charles L. Corradino, New Haven
Marvin L. Cousins, New Haven
Sidney L. Cramer, Hartford
M. A. Crispin, Hartford
M. D. Deren, Bridgeport
G. de Suto-Nagy, West Haven
I. K. de Suto-Nagy, New Haven

Michael J. DeVito, Hartford
H. A. DiBlanda, Weston
Bernard S. Dignam, Thompsonville
John Donnelly, Hartford
William F. Donovan, West Hartford
Edward Dorian, New Britain
Louis I. Dublin, Westport
Charles E. Dutchess, Newtown
Jack J. Falsone, Jr., South Norwalk
A. Arthur Fierberg, Hartford
Edward M. Finesilver, Hartford
Robert K. Finley, Niantic
Robert A. Fox, Norwalk
Morris Freedman, New Haven
John M. Freiheit, Waterbury
Isadore H. Friedberg, Newington
Francis Gallo, Winsted
George J. Geanuracos, Bridgeport
Robert P. Gerety, Fairfield
V. B. Ginsburg, Hamden
Frederick W. Goodrich, Jr.,
New London
I. A. Gorman, Bridgeport
Harry R. Gossling, Hartford
Howard M. Gourlie, Thompsonville
H. Howard Green, Norwalk
Gerald S. Greene, Hartford
Jacob Greenblatt, Hartford
Barnett Greenhouse, New Haven
W. Hadisurnarto, New Haven
John W. Haine, Stamford
Joseph Hamburg, Stamford
H. Patterson Harris, Fairfield
Clarence W. Harwood, Middletown
John W. Haine, Stamford
John R. Heafey, Norwalk
Albert E. Herrmann, Waterbury
E. Roland Hill, Mystic
William E. Hill, Naugatuck
William H. Horton, Windsor

N. W. Humpage, Torrington
N. B. Jaffe, Bridgeport
Milton L. Jennes, Waterbury
Carl E. Johnson, Hamden
J. H. Johnston, Hartford
Thomas F. Jones, Danielson
Leon Kaplan, Bridgeport
John F. Kilgus, Hartford
Henry W. Kumm, Greenwich
Robert C. Keys, South Norwalk
Ben M. Lanman, Riverside
Albert A. Laplume, Bristol
A. L. Larson, Hartford
Aaron Levinsky, Bridgeport
Sidney Licht, New Haven
S. E. Lifton, Hartford
Howard J. Lockwood, Manchester
Benjamin E. Lyons, Norwalk
William R. Maniatis, Bridgeport
Allen M. Margold, Norwalk
M. Margolick, Putnam
Charles D. Marple, Rowayton
Stevens J. Martin, Hartford
George W. Mast, Ridgefield
James E. Mazzacane, Bridgeport
Robert T. McSherry, New Haven
James V. Minor, Norwalk
L. E. Morrissett, Greenwich
Victor J. Mulaire, Stamford
William J. Murray, New London
David Nargournex, Bridgeport
Abbott A. Newman, Bridgeport
Robert W. Nespor, Westport
Jacob Nodelman, New Haven
Frank T. Oberg, Bridgeport
P. H. O'Connell, Norwich
E. Orbach, New Britain
Kurt A. Oster, Bridgeport
J. C. Quatrano, Bridgeport
Edward A. Rein, Norwalk

Joseph Reiss, Newtown
 Whitman M. Reynolds, Greenwich
 W. H. Resnick, Stamford
 William H. Rider, New Haven
 Louis Rogol, Danbury
 Oscar Rogol, Seymour
 Ernestine Rosenberg, Bridgeport
 Hans Rosenberg, Bridgeport
 Saul Rosenberg, Bridgeport
 Albert Ruben, Hartford
 D. J. Sabia, Stamford
 Daniel P. Samson, Thomaston
 M. M. Scarborough, New Haven
 Walter A. Schloss, Hartford
 Frank A. Serena, South Norwalk
 Marguerite Shepard, Newington
 Benjamin Sherman, Bridgeport

Homer B. Shoup, Westport
 David N. Shulman, Hartford
 Gertrude Slater, Hartford
 Norman N. Smith, New Haven
 Wilson F. Smith, Hartford
 W. Leslie Smith, Hartford
 Alan R. Small, Bridgeport
 Thomas Soltzman, New London
 Nicholas V. Spinelli, Bridgeport
 E. Myles Standish, Hartford
 Joseph J. Stapor, Derby
 Julius D. Stein, Bridgeport
 Carter Stilson, New Haven
 Jack Sutton, Groton
 William D. Swartz, Greenwich
 Henry P. Talbot, Hartford
 S. P. Taylor, North Haven
 Marcel Thau, Hartford

Paul W. Tisher, New Britain
 Donald E. Tinkess, Greenwich
 F. Erwin Tracy, Middletown
 Frank D. Ursone, Norfolk
 Abraham Vinograd, New Haven
 Charles K. Wallace, Hartford
 Victor G. H. Wallace, Hartford
 Frederick C. Weber, Jr., Greenwich
 Eber A. Wein, New London
 William Weiner, Danbury
 Ellwood C. Weise, Bridgeport
 E. C. Weise, Devon
 Morris A. Wessell, New Haven
 R. C. Whiting, Hartford
 John C. Wienski, West Hartford
 John B. Zielinski, Bridgeport
 William W. Zeller, Hartford

SCIENTIFIC EXHIBITS

The display of developments in the field of scientific medicine offered to those attending the annual meeting of the AMA at Atlantic City this year seemed to surpass all previous exhibits. It was a veritable encyclopedia of knowledge available to physicians. Many hours, even days could be spent studying the material presented. For example, there was the exhibit on General Hypothemia in Surgery which won the Hektoen Gold Medal for the best in original investigation and presentation and was displayed by a group from the University of Colorado Medical Center. Then the group at the Jackson Memorial Laboratory at Bar Harbor, Maine ran close second with their exhibit on Experimental Procedures for Inducing Acceptance of Tumor Grafts. Third place in this group went to two physicians at Sloan-Kettering Institute, New York City, for their exhibit on Serum Glutamic Oxalacetic Transaminase Variations in Heart and Liver.

The other group of exhibits judged on the basis of excellence of correlating facts and excellence of presentation but not representing purely experimental studies found a group from Mayo Clinic in first place with their exhibit on Esophagitis: A Common Condition Frequently Overlooked. In second place was the exhibit on Angiocardiography in Normal and Abnormal Hearts presented by a group from the Hektoen Institute for Medical Research in Chicago, while third place went to the exhibit on Periodic Health Appraisal: Methods and Results of Examinations displayed by a group from the University of Michigan.

Each Section received a Certificate of Merit as well as an Honorable Mention for exhibits in its

particular field. They were of such an excellent character selection must have been difficult. Particularly impressive was the exhibit on Hypokinetic Disease which received Honorable Mention in the Section on Physical Medicine and Rehabilitation. If you do not believe the American people are becoming soft you have only to study the results of muscle testing carried out in the different age groups of our population over a period of 15 years by the New York group under Dr. Hans Kraus. In the next booth Dr. Edward Scull and Miss June Sokolov from the Rehabilitation Center in Hartford were on hand to greet us and to emphasize the details of their fine exhibit on Conquering Crippling Through a Community Rehabilitation Center.

The Army exhibited to the public for the first time rubber models of common combat wounds used in training its men in first aid. Also it had on display its new portable x-ray unit powered by radioactive thulium, which may soon be available for use on the battlefield. This device can produce an x-ray picture without electricity, water or a darkroom.

The U. S. Air Force had set up on the beach in front of the boardwalk its newly developed 36 bed air-transportable hospital. This hospital when packaged is no larger than a roomy bathroom and can be loaded aboard a C-54 cargo plane and flown wherever required in a matter of hours. It contains all the medical facilities necessary to support a Strategic Air Command bomb wing operating anywhere in the world for a 90 day period.

The Naval Medical Field Research Laboratory at Camp Lejeune, N. C. demonstrated what makes a safe automobile driver. This exhibit was the result

of the work of Lieut. Frederick L. McGuire and his department of psychology at Camp Lejeune and showed that accidents are due not mostly to luck but are the result to be expected from poor drivers.

TECHNICAL EXHIBITS

On the floor of the technical exhibits there was little that was new. True, there were improvements in certain instruments as one might expect and refinements in office operating procedures for the physician whose practice required the use of modern business methods. Bessie the Borden cow was there and the Sealy mattress girl was to be seen still rubbing her aching back. Missing were the long lines of cigarette smokers waiting to receive their monogrammed supply of the weed for cigarette advertising has been banned from all the AMA publications. The ardent admirers of Revlon cosmetics and of Bib orange juice, Coca-Cola, and Pepsi-Cola filled the aisles in front of these booths. We missed some of our old friends but it may have been because of their more modest attire rather than their actual absence.

SCIENTIFIC PROGRAM

In the Scientific Sessions Connecticut was represented by Francis J. Braceland of Hartford, chairman of the Section on Nervous and Mental Diseases, who delivered his Chairman's Address at the second session of the Section, and by Ralph M. Tovell of Hartford who discussed "The Value of Drugs, Oxygen, and Carbon Dioxide as Stimulants to Respiration in the Apneic Infant" at the joint session of the Sections on Anesthesiology, Diseases of the Chest, General Practice, Obstetrics and Gynecology, and Pediatrics.

COLOR MOTION PICTURES AND TV

Forty medical films were shown throughout the sessions, several of them for the first time. There was the full color motion picture of the passage of the egg through the Fallopian tube into the uterine cavity, the birth of a baby following abdominal pregnancy, the responses of mentally ill patients to treatment with the drug, Rauwolfia Serpentina, and the use of an artificial heart stimulator on a patient for seven days. One of the premieres was a film showing the result of a study of amyotrophic lateral sclerosis in the Mariana Islands. With the development of electronic fluoroscopic equipment a film was presented showing the movement of fluid through the urinary tract. Another film demon-

strated evidence of the persistence of the thymus gland in mammals despite its seeming uselessness.

Twenty-three hours of "live" clinics and surgical operations were beamed in color during the sessions. This was the 75th clinical television program produced by Smith, Kline and French Laboratories and the 13th presented for the AMA. Perhaps the most interesting was the demonstration of a color television electronic microscope capable of magnifying material 15,000 times. The clinic and operations were all beamed from the hospital of the University of Pennsylvania in Philadelphia.

INAUGURATION CEREMONY

"Medicine's Proclamation of Faith" was the theme at the inauguration of Elmer Hess, president of the American Medical Association. It was an impressive ceremony with an audience present which filled the ballroom of Convention Hall. The Temple University Concert Choir sang several numbers with a finesse which gave evidence of excellent training. Dr. Hess emphasized the physician's need for faith in caring for the ills of mankind. He was followed by Rev. Norman Vincent Peale of New York City who spoke on "Medicine and Faith."

CONFERENCE OF PRESIDENTS

Preceding the sessions of the AMA the Conference of Presidents and Other Officers of State Medical Associations held its annual session. The incoming president of the Conference, Charles L. Farrell, M.D., of Pawtucket, R. I., ably called attention to the long list of medico-economic problems with which medicine is faced today and suggested methods of approach to these problems. James R. Fox, M.D., of Minneapolis described his experiences while practising in England for two years under the British National Health program. His information added little to our present knowledge of the plight of the general practitioner in England but his personal experiences made more emphatic the need for constant vigilance in our own country against the inroads of socialization. Senator John W. Bricker very ably explained his stand in support of the Bricker Amendment now before Congress. One could not listen to him without being impressed by the logic and wisdom of his reasoning. Herbert Philbrick entertained and educated the audience with the story of his experiences as a member of the Communist Party in Cambridge, Massachusetts while serving as a special agent for the Federal Bureau of Investigation.

HOUSE OF DELEGATES

Osteopathy, medical ethics, medical practices, intern training, hospital accreditation and polio vaccine were among the major topics of discussion by the House of Delegates at the American Medical Association's 104th Annual Meeting held June 6-10 in Atlantic City.

Elected unanimously as president elect for the coming year was Dwight H. Murray, general practitioner of Napa, California, who has been a member of the AMA Board of Trustees for ten years and its chairman for the past four years. Dr. Murray will become president of the American Medical Association at the June, 1956 meeting in Chicago, succeeding Dr. Elmer Hess of Erie, Pennsylvania. Dr. Hess took office at the Tuesday evening inaugural program in Atlantic City's Convention Hall.

The House of Delegates voted the 1955 Distinguished Service Award of the American Medical Association to Donald G. Balfour, surgeon, author and researcher of Rochester, Minnesota, for his outstanding contributions to medicine and humanity. Dr. Balfour has been with the Mayo Clinic since 1907 and he also has been associate director and then director of the Mayo Foundation for Medical Education and Research. His son, Dr. William Balfour, accepted the award for his father at the Tuesday inaugural program.

THE OSTEOPATHIC ISSUE

The Reference Committee on Medical Education and Hospitals submitted two reports after considering the recommendations of the Committee for the Study of Relations Between Osteopathy and Medicine. The minority report, which was adopted by the House of Delegates, said:

"One member of the Reference Committee was completely satisfied that an appreciable portion of current education in colleges of osteopathy definitely does constitute the teaching of 'cultist' healing, and is an index that the 'osteopathic concept' still persists in current osteopathic practice. Since he cannot with good conscience approve the recommendation that doctors of medicine teach in osteopathic colleges where 'cultism' is part of the curriculum, he respectfully makes the following recommendations to the House of Delegates:

"(1) That the report of the Committee for the Study of Relations Between Osteopathy and Medicine be received and filed; and that the Committee

be thanked for its diligent work, and be discontinued.

"(2) That if and when the House of Delegates of the American Osteopathic Association, their official policy-making body, may voluntarily abandon the commonly so-called 'osteopathic concept,' with proper deletion of said 'osteopathic concept' from catalogs of their colleges; and may approach the Trustees of the American Medical Association with a request for further discussion of the relations of Osteopathy and Medicine, then the said Trustees shall appoint another special committee for such discussion."

The majority report of the reference committee, which was rejected by the House, made the following recommendations:

"Your Reference Committee after a study of the report of the Committee for the Study of Relations Between Osteopathy and Medicine and the study of other evidence submitted is not completely satisfied that the current education in colleges of osteopathy is free of the teaching of 'cultist' healing.

"In view of the desire to elevate the standards of teaching in colleges of osteopathy, your Reference Committee recommends approval of the recommendation of the Committee that doctors of medicine may accept invitations to assist in osteopathic undergraduate and postgraduate medical educational programs in those States in which such participation is not contrary to the announced policy of the respective county and state medical associations. Such teaching services would be ethical.

"Your Reference Committee approves the recommendation of the Committee that the House of Delegates request state medical associations to assume the responsibility of determining the relationship of doctors of medicine to doctors of osteopathy within their respective States or request their component county societies to do so.

"Your Reference Committee recommends that a committee be appointed at the discretion of the Board of Trustees to confer with representatives of the American Osteopathic Association concerning common or inter-professional problems on the national level."

CHANGE IN MEDICAL ETHICS

The Reference Committee on Miscellaneous Business dealt with ten resolutions concerning the dispensing of drugs and appliances by physicians. None of these recommendations was adopted.

The Committee recommended deletion of Section 8, Chapter I of the Principles of Medical Ethics which read:

"Ownership of Drugstores and Dispensing of
Drugs and Appliances by Physicians

"Sec. 8. It is unethical for a physician to participate in the ownership of a drugstore in his medical practice area unless adequate drugstore facilities are otherwise unavailable. This inadequacy must be confirmed by his component medical society. The same principle applies to physicians who dispense drugs or appliances. In both instances, the practice is unethical if secrecy and coercion are employed or if financial interest is placed above the quality of medical care. On the other hand, sometimes it may be advisable and even necessary for physicians to provide certain appliances or remedies without profit which patients can not procure from other sources."

In lieu of the above paragraph the following was adopted:

"Dispensing of Drug and Appliances
by Physicians

"Sec. 8. It is not unethical for a physician to prescribe or supply drugs, remedies, or appliances as long as there is no exploitation of the patient."

In reporting to the House the chairman of the Reference Committee explained that in the opinion of the Committee the Code of Ethics should be stated in broad principles rather than attempt to interpret principles in detail. In recommending the change in Section 8 the Committee emphasized that this section should be interpreted in line with Chapter I, Section 6, which reads: "The ethical physician, engaged in the practice of medicine, limits the sources of his income received from professional activities to service rendered the patient . . ."

MEDICAL PRACTICES COMMITTEE REPORT

The Reference Committee on Insurance and Medical Service, which considered two Board of Trustees reports on the Report of the Committee on Medical Practices, recommended endorsement of the Board's principal conclusions and recommendations. The House of Delegates, however, adopted a substitute motion postponing action until next December. The motion also called for distribution of the entire report of the Committee on Medical Practices to all delegates, so that they can study it carefully before the 1955 Clinical Meeting in Boston.

INTERNSHIP APPROVAL PROGRAMS

The House adopted the following statement presented by the Reference Committee on Medical Education and Hospitals:

"Your Committee has reviewed the report of the Council on Medical Education and Hospitals which includes a summary of the reports previously made to the House of Delegates by the Ad Hoc Committee on Internships and are in agreement with the Council that these conclusions and recommendations are eminently sound and that they should be incorporated into the principles and policies employed by the Council in the conduct of its internship approval programs including subsequent revisions of the Essentials of an Approved Internship.

"Your Committee wishes specifically to reaffirm the following recommendations of the Ad Hoc Committee on Internships:

"(1) That a continuing study be made as to what should be the content of an internship; what constitutes sound clinical experience during the internship year.

"(2) That the 'one-fourth rule' be adopted: Any internship program that in two successive years does not obtain one-fourth of its stated complement be disapproved for intern training. It was pointed out to your Committee in the hearings that statistical data compiled for a period of two years indicated that enforcement of this rule would have displaced only a few interns."

HOSPITAL ACCREDITATION

The same reference committee considered six resolutions on hospital accreditation and presented the following statement which was adopted by the House:

"Your reference committee has reviewed all these resolutions which in principle are similar and apparently reflect a widespread dissatisfaction with the present functioning of the Joint Commission on the Accreditation of Hospitals, possibly from bilateral misunderstandings. Therefore, your reference committee recommends that the Speaker of the House of Delegates be requested to appoint a special committee to review the functions of the Joint Commission on the Accreditation of Hospitals to consist of seven members, none of whom shall be members of the Council on Medical Education and Hospitals or the Joint Commission on the Accreditation of Hospitals. This special committee should be instructed to make an independent study or

survey and report its findings and recommendations to the House of Delegates at the next annual meeting. All physicians and hospitals are urged to pass on to this special committee any observations or suggestions concerning the functioning of the Joint Commission on the Accreditation of Hospitals."

POLIO VACCINE

The House passed three resolutions suggested by the Reference Committee on Hygiene, Public Health and Industrial Health in connection with discussion of the Salk polio vaccine and the introduction of new methods in the treatment or prevention of disease.

The first resolution reaffirmed "confidence in the established methods of announcing new and possibly beneficial methods in the treatment and prevention of disease" and also reaffirmed "the need for the presentation of reports on medical research before established scientific groups, allowing free discussion and criticism, and the publication of such reports, including methods employed and data acquired on which the results and conclusions are based, in recognized scientific publications."

The second resolution included the following policy statements:

"Resolved, That the American Medical Association go on record as disapproving the purchase and distribution of the Salk polio vaccine by any agency of the federal government except for those unable to procure it for themselves and that such necessary federal funds therefor be allocated to the various proper State agencies for such purpose; and be it further

"Resolved, That the American Medical Association urge the Congress of the United States to allow the Salk polio vaccine to be produced, distributed and administered in accordance with past procedures on any new drug or vaccine."

The third resolution commended Dr. Salk as follows:

"Whereas, The physicians of this country recognize the great scientific achievement in isolating and perfecting a vaccine for the prevention of poliomyelitis by Dr. Jonas Salk; and

"Whereas, This vaccine is now being used to prevent poliomyelitis among many of our children; therefore be it

"Resolved, That the House of Delegates express its profound gratitude to Dr. Salk and its admiration

for his monumental contribution to medical science."

MISCELLANEOUS ACTIONS

Among a large number of actions on a wide variety of subjects, the House of Delegates also:

Commended the "Medic" television program;

Reaffirmed its previous recommendation that the United States withdraw from the International Labor Organization;

Approved the Headquarters Survey Report, which included the statement that "the only public relations program of any permanent value is the private and public relations of the individual doctor;"

Expressed regret that the Hoover Commission saw fit to alter or eliminate some of the recommendations of its Medical Task Force;

Reaffirmed its opposition to extension of the Doctor Draft Law;

Recommended the creation of an AMA Committee on Geriatrics;

Warned against the danger embodied in State legislative proposals designed to restrict the entire field of visual care to the profession of optometry;

Urged the reporting in each State on the use of safety belts in automobiles as recorded in the event of accidents;

Went on record supporting the development of a more active civil defense program in each State;

Changed the name of the Council on Physical Medicine and Rehabilitation to the Council on Rehabilitation, and changed the name of the Section on Physical Medicine and Rehabilitation to the Section on Physical Medicine with provision for a joint session at each annual meeting devoted to Rehabilitation;

Requested Board of Trustees to institute a U. S. Medical Hall of Fame;

Referred the controversial subject of the operation of the Welfare and Retirement Fund of the United Mine Workers to the Councils on Medical Service and Industrial Health for further study;

Referred four resolutions dealing with voluntary health insurance plans to the Commission on Medical Care Plans now carrying on a study of the same. One of these resolutions introduced by Dr. Danaher from Connecticut endeavored to set up certain concepts for the solution of the cost of medical care through voluntary prepayment plans;

Referred to the Board of Trustees the entire problem of general practice experience prior to specialization with instructions to increase the size of the Committee on General Practice Experience;

Went on record opposed to the establishment of service connection by presumption for disabilities developing after the termination of military service;

Endorsed HR4444, Student Aid bill;

Expressed opposition to federal aid to medical education in any form;

Protested the disruption and interference with medical school training programs by the drafting of medical students who elect to interrupt their medical education to become assistants in the preclinical science departments;

Referred the question of exclusion of obstetrics and gynecology from a straight internship to the council on Medical Education and Hospitals for further consideration.

OPENING SESSION

Principal addresses at the Monday opening session of the House of Delegates were given by Dr. Walter B. Martin of Norfolk, Virginia, retiring AMA president, and Dr. Elmer Hess of Erie, Pennsylvania, then president elect. Dr. Martin declared that the basic philosophy of medicine has not changed and "our obligation is to bring the best that medicine can offer to the individual patient." Dr. Hess said that the nation's physicians must become leaders in a campaign to "overcome the ravages of mental illness" as well as in an "intensive campaign to eliminate the needless bloodshed" of traffic accidents.

ELECTION OF OFFICERS

The following officers were elected at the closing session, in addition to Dr. Murray, the new president elect:

Millard D. Hill, Raleigh, North Carolina, vice president; George F. Lull, Chicago, secretary; J. J. Moore, Chicago, treasurer; E. Vincent Askey, Los Angeles, speaker of the House of Delegates, and Louis M. Orr, Orlando, Florida, vice speaker.

Gunnar Gundersen, La Crosse, Wisconsin, was named chairman of the Board of Trustees to succeed Dr. Murray. James R. Reuling, Bayside, N. Y., was elected to fill Dr. Murray's term on the Board. Reelected as trustees were L. W. Larson, Bismarck, North Dakota, and T. P. Murdock, Meriden, Connecticut.

Louis A. Buie, Rochester, Minnesota, was named by Dr. Hess to succeed himself on the Judicial Council. Elected to the Council on Medical Education and Hospitals were Harlan English, Danville, Illinois, and James M. Faulkner, Boston, the latter succeeding himself. Reelected to the Council on Medical Service was H. B. Mulholland, Charlottesville, Virginia. Elected to the same Council were A. C. Scott, Temple, Texas, and R. B. Chrisman, Jr., replacing Dr. Orr.

B. E. Pickett, Sr., Carrizo Springs, Texas, was reelected to the Council on Constitution and By-Laws, and Warren Furey was named to the same Council to replace James Stevenson, Tulsa, Oklahoma.

Dr. Heller Executive Secretary of New Society

John H. Heller of Wilton, executive director of the New England Institute for Medical Research in Ridgefield, was elected executive secretary of the Society for Research on the Reticuloendothelial System at its meeting recently in San Francisco. Members of this new research group are specialists in internal medicine, microbiology, endocrinology, immunology, nutrition, and radiology. Ridgefield will be national headquarters for the society which is headed by Dr. Charles Doan, dean of the Medical School of Ohio State University.

Dr. Heller was formerly on the faculty of the Yale University School of Medicine and is now engaged in active research on the reticuloendothelial system at the New England Institute.

The society represents a culmination of several years of thinking and planning to encourage and stimulate increasing activity in the broad field of humoral and cellular phases of resistance to many different types of disease.

The organization is planned to cut across all specialty discipline lines and to bring together at least once a year investigators in many different fields from all over the world, so that they can share information in this vital and growing area.

The reticuloendothelial system of cells in the human body is the interest that drew these varied researchers together in the formation of the society in April of 1954. The membership represents more than 120 institutions of learning and hospitals in the United States, Europe, South America and the Middle East.

NEWS FROM WASHINGTON

Health Legislation

As we go to press there seems to be very little accomplished by the present Congress. A record amount of medical legislation has been introduced but no record set for laws passed. Most of the measures that were offered in January and February, to the accompaniment of hopeful speeches by their sponsors, have been allowed to lie undisturbed in committee files. In some cases hearings were held, where persons and organizations vitally interested could give enthusiastic testimony. Very few bills indeed got farther than that in the first six months of the session.

Also, key committees for weeks were preoccupied with various bills on Salk vaccine, its control and its cost—weeks when the committees otherwise might have worked on, and possibly reported out, other less controversial health bills. A specific example is the Senate Labor and Welfare Committee. This committee was about ready to report out a House passed bill for a national survey of mental health problems when it found itself deeply mired in the Salk situation. The mental health bill still is likely to be enacted, but the long delay didn't help much.

Another bill, early in the session regarded as about certain of enactment, calls for the establishment of a voluntary, contributory system of health insurance for federal civilian employees. After a year's study of the complications involved, a special task force prepared and made public the administration's program in January. The expectation was that a bill to carry out the plan would be offered in a few weeks at the most, and would be passed in a few months.

But it didn't work out that way. The administration decided that it couldn't press for these medical benefits (U. S. would pay about one-third of insurance premiums) until the extent of a general U. S. pay raise had been fixed by Congress. So it was June before this U. S. employee health insurance bill was even sent to Congress, and then the administration was in no rush to have it passed.

Troubles also beset the Defense Department's bill

to extend the doctor draft act another two years. Although the extension was strongly opposed by both the American Medical Association and the American Dental Association, the House Armed Services Committee accepted the Defense Department's arguments and voted out the bill, 24 to 0.

Ordinarily such a committee vote would have sent the bill sailing on through the House and to the Senate. But not this time. Chairman Howard Smith (D—Virginia) of the House Rules Committee lectured the Armed Services Committee and the Defense Department for not making an effort to solve the doctor problem by some other means. There was consequently a delay before floor action—not fatal, but a delay.

Some bills, once considered important, were effectively ignored by Congress. One was the Eisenhower-Hobby plan for reinsurance of health insurance groups, defeated last year. The administration tenaciously defended it, but the committees weren't enough impressed to schedule hearings during the first six month of the session.

The administration bill for federal guarantee of construction loans for hospitals and clinics stirred some Capitol Hill interest but no hearings have been held. Then came all the bills on polio vaccine, and this measure also was put on the shelf.

A bi-partisan bill for U. S. grants for constructing and equipping medical research facilities travelled about the same course: hearings, a high degree of enthusiasm from medical researchers, confidence that the plan would go through—then no more action.

For a time Senator Hill (D—Alabama), the key Senator on health bills, was determined to put through his bill for federal aid for building medical schools. When hearings were held the bill did not appear to arouse opposition from any quarter, yet it was pushed farther and farther to the rear.

Because this is only the first session of the 84th Congress, none of these bills will be irretrievably lost even if not passed before adjournment. They hold whatever progress they have made, and many of them are certain to be important issues next year.

Train More Doctors, Aid Research: Hoover Report

Made public early in June, Hoover Commission report on Federal support of research and development takes a much more militant stand on medical research than was evident in separate report last February on Federal medical services in general, including research. The latter's only major recommendation was that government aid grants should be on a long range, rather than a yearly basis. It made no case for a large money buildup of Federal support.

By contrast, this latest report of the Commission not only calls for greatly increased government grants but charges there is a shortage of doctors which is the result of insufficient financial support by Washington. "We cannot afford stagnation of our medical research in our medical schools or the training of our technicians," says the report. "We must make sure of general support to this field which daily demonstrates such potential benefits for mankind. We urge also that this is a problem for the Nation as a whole."

It administers a rebuke to the White House for failure to apprise Congress of the backlog of research grant applications pending in National Institutes of Health.

New Senate Legislation

S1859—Federal Aid for Public Health Education. (Humphrey, D—Minnesota, May 2.) Would provide five-year emergency grants and scholarships program for postgraduate study in ten public health schools. Provisions: Five-year period, \$5 million for outright subsidies, \$5 million for construction grants (on a 50-50 matching basis) and a total of \$1,250,000 for scholarships. The ten accredited public health schools are California, Columbia, Harvard, Johns Hopkins, Michigan, Minnesota, North Carolina, Pittsburgh, Tulane and Yale. The bill provides for grants on the basis of 15 per cent of basic operating costs of graduate instructions plus an additional \$500 for each full time student in excess of average past enrollment and an additional \$500 for each enrollment in excess of 30 students. Maximum per school would be 50 per cent of basic operating cost of the school. Sen. Humphrey introduced an identical bill in the last Congress (S461). Labor and Public Welfare.

Education Getting More U. S. Gifts Than Health

Latest monthly report by Department of Health, Education and Welfare reveals that it allocated more than \$13.5 million in March to the States and territories in Federal surplus property. HEW estimates that by fiscal year's close on June 30, it will have distributed in excess of \$150 million worth of surplus items as gifts to tax-supported and nonprofit educational and health institutions. Eighty per cent of this total will go to universities and schools, only 20 per cent to clinics, hospitals and other health agencies. One reason for this disproportion is that the program got an earlier start in field of education.

HEW's allocations in current fiscal year are running better than 25 per cent ahead of 1953-54 and will total almost as much as the three previous fiscal years combined.

Statistical Data Given On Long-Term Disabled

Mounting pressure for broadening social security coverage to include disability insurance lends timeliness to a report just published by Social Security Administration. It estimates at 5.3 million the number of Americans who for six months or longer have been unable to work or follow normal pursuits due to physical or mental disease or impairment. Nearly three million are between ages of 14 and 64; 1.2 million are in institutions. An estimated 75 per cent of those in 14-64 group would be in gainful employment but for their prolonged disability.

Children's Health Care

Another SSA report deals with public expenditures for medical care of dependent children. This is provided under State public assistance programs and through direct payment by public welfare agencies to hospitals, physicians and other providers of services. The latter, known as vendor payments, accounted for expenditures of \$15.6 million in fiscal year 1954, when 22 States were employing this means of direct compensation. In January of this year, vendor payments average \$2.52 per family. By States, the range was wide—from \$17 in Connecticut and \$13.50 in New Hampshire to 5 mills in Alabama.

YOUR CONTRIBUTION TO THE
1955 AMEF CAMPAIGN —

- Will help assure widespread participation of the medical profession in the drive to balance medical school budgets.
- Will encourage contributions from industry and other corporate donors.
- Will help medical schools maintain the high standards needed to properly train future physicians.
- Will help preserve academic freedom and the leadership of American medicine.

IF YOU HAVEN'T CONTRIBUTED,
DO IT NOW

AMERICAN MEDICAL EDUCATION FOUNDATION
Fund-Raising Committee
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I wish to contribute the enclosed amount to help our medical schools.
Please earmark my contribution:

- 1. For AMEF General Fund ☐
- 2. For
(Name of Medical School)



Signed: M.D.
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Hartford County Physicians Present Health Education Telecast

William H. Upson, Suffield, and Robert Walker, Hartford, were panelists on a television program presented by the State Medical Society and the Hartford County Medical Association, May 26, from the studios of WKNB-TV.

Entitled "When You're the Patient," the 15 minute program was one of a series presented in cooperation with the Connecticut TV Committee for Health Education with Robert Wakeley, health educator for the Connecticut Division of the Connecticut Cancer Society, as moderator.

"Accent on Living," is the theme of the series which is produced by committee members who represent the State Health Department, State Medical Society, 12 statewide voluntary health agencies and four television stations.

The series will be continued through the summer with two additional programs to be produced by the State Medical Society on August 18 and September 29.

Willimantic Physicians Reorganize Emergency Call Plan

Members of the professional staff of Windham Community Memorial Hospital recently organized a continuous, 24 hour emergency medical call plan for residents of the area. The new plan replaces one that previously used the same facilities but was not as completely organized. The plan was announced by William Maurer, secretary of the professional staff and has been given wide publicity to acquaint residents of the area with this new community service. The service has been arranged through the cooperation of the Willimantic Medical Society, the Windham County Medical Association and the Windham Community Memorial Hospital and began operating the first of June.

Norwalk Medical Society Expands Emergency Service

Residents of Norwalk, Westport, Darien, Wilton, Ridgefield, New Canaan, Georgetown, Greens Farms and Weston will benefit from the recent expansion of an emergency medical call system sponsored by the Norwalk Medical Society.

The plan utilizes the communication facilities of answering services, community police headquarters and the Norwalk Hospital. The telephone numbers for use in each community are publicized through daily and weekly newspapers in the area and a panel of physicians for emergency service has been organized for each community.

In announcing the plan, officers of the Norwalk Medical Society urged that it be used only in real emergency and that residents make every reasonable effort to reach their family physician before dialing the emergency numbers.

Summer Schedule for "Medic"

The National weekly television program, "Medic," sponsored by the Dow Chemical Company in cooperation with the Los Angeles County Medical Association, will rerun a number of its most popular programs during the summer season.

The programs will be presented at 9:00 P. M., E.D.T., over the NBC-TV network on the following dates: July 4: "I Climb the Stairs;" July 11: "Laughter Is a Boy;" July 18: "Break Through the Bars;" August 1: "Boy in the Storm;" August 8: "The Wild Intruder;" August 15: "Dr. Impossible;" August 29: "Flash of Darkness."

Hill-Burton Program Now Beyond \$2 Billion Mark

Hill-Burton hospital expansion, due to mark its tenth birthday next year, has gone past \$2 billion

level. As of April 30, project approvals to date totaled 2,481, with an aggregate estimated cost of \$2,004,549,450. Projects completed and in operation number 1,876 and 448 are under construction, with remaining 157 still in the initial approval stage. Over-all program provides for addition of 116,983 hospital beds and 458 health centers, plus 78 health centers integrated with general hospitals. Federal financial contribution is \$662,720,377, or about third of total.

Medical Society Executives Conference Elects Officers

M. C. Smith, executive secretary, Nebraska State Medical Society, was elected president of the Medical Society Executives Conference at the 9th Annual Meeting of the organization, held in Atlantic City, June 4, in conjunction with the National Conference of the American Medical Association.

Lester H. Perry, executive secretary of the Medical Society, State of Pennsylvania, was named president elect and H. Martin Baker, executive secretary, Sedgwick County Medical Society, was elected secretary-treasurer.

The conference program included a general session presided over by Charles Lively, executive secretary, West Virginia State Medical Association, retiring president of the organization, and four group discussions on the administration of medical association programs.

Begin Survey of County Medical Society Activities

Every two years the AMA Council on Medical Service conducts a survey of county medical society activities. The purpose is to provide up-to-date information to the many county society officers who write to AMA headquarters concerning medical society operations.

The Council, in conjunction with the Public Relations Department, will mail a comprehensive questionnaire to secretaries of all county medical societies. Secretaries are requested to fill out the questionnaire and return it as soon as possible.

An accompanying letter, signed by Dr. J. D. McCarthy, chairman of the council, said that "we have tried to make the questionnaire all inclusive and yet easy to fill out—mostly with yes or no answers."

LETTERS TO THE EDITOR

Television Program — AMA Clinical Session, Boston

To the Editor:

Physicians of New England are showing a most gratifying spirit of cooperation in the early planning for the Clinical Session of the American Medical Association to be held in Mechanics Building, Boston, for the four days from November 29 to December 2, 1955.

One feature of the session will be the television programs (in color) which will be possible through the generosity of Smith, Kline and French Laboratories of Philadelphia.

Television programs will originate from the New England Deaconess Hospital and sent by closed circuit to a special hall in Mechanics Building. The morning programs will be surgical in nature and demonstrate operations by surgeons on the staff of the Deaconess. The afternoon programs will consist of talks, demonstrations and panel discussions on medical subjects.

Participation in the afternoon medical programs is open to all, subject to acceptance by the Committee. Physicians desiring to take part are urged to send in abstracts promptly, summarizing the proposed presentation in not more than 300 words. In addition, ideas or suggestions for appropriate topics and participants in either the surgical or medical programs will be welcomed by the Committee. Prospective participants should keep in mind that a successful television demonstration must have visual interest. One must avoid reading a paper before the camera and the presentation should be built around patients, instruments, apparatus, charts, slides and x-rays. There will be no facilities for showing films or movies. Participants will be given information on television appearance and on size and color of charts and slides at a special orientation meeting which will be held 6-8 weeks prior to the meeting.

Proposals and suggestions should be sent to the Chairman of the Television Committee, Alexander Marble, M.D., 81 Bay State Road, Boston 15, Mass.

Sincerely yours,

C. Cabell Bailey, M.D.

Alexander Marble, M.D.

Kenneth W. Warren, M.D.

Is the Use of Epinephrin Dangerous in Connection With Procaine in Dental Procedures?

There have been so many diverse opinions in regard to unfavorable action of Epinephrin in connection with Procaine for dental and oral surgical procedures, that the Council of the New York Institute of Clinical Oral Pathology decided to get an authoritative opinion which could be used as a guide to the practitioner in the care of patients who suffer with diseases of the heart and the circulatory system.

On December 10, 1953, the following letter was therefore addressed to the New York Heart Association:

"Our Institute is most interested to get an opinion on the use of Epinephrin in connection with Procaine as a local anesthetic in patients with diseases of the heart and circulatory system. The opinions of heart specialists are so divergent that in the interest of the medical and dental professions this subject should be referred to a special committee for study."

The correspondence was completed with a letter from the New York Heart Association dated October 5, 1954, which reads:

"In further answer to your letter of April 16, 1954 regarding the use of epinephrin in dental practice on cardiac patients,

"This matter has been carefully studied by a committee appointed by the New York Heart Association for that purpose. I believe the enclosed report of this committee is a complete answer to the question which you have raised. This report has been approved by our policy committee for transmission to you.

"Please let me know of any further information you may wish to request."

REPORT OF SPECIAL COMMITTEE ON THE USE OF EPINEPHRIN IN CONNECTION WITH PROCAINE IN DENTAL PROCEDURES

NEW YORK HEART ASSOCIATION, INC.

Your committee submits the following report on the use of epinephrin in connection with procaine as a local anesthetic for dental procedures in patients with diseases of the heart and the circulatory system:

I. It is our understanding of common dental practice that epinephrin is used in dilutions of 1:50,000

and occasionally 1:100,000; never more concentrated than 1:50,000. Rarely more than 2.0 cc. of solution are used in any one session.

II. Epinephrin is combined with a local anesthetic, commonly procaine. One of the pharmacological actions of procaine is to counteract the tendency of epinephrin to cause cardiac irregularities.

III. The dentist should have information from the physician about the nature and severity of the heart disease in the patient. He should also have knowledge of medication the patient is receiving, particularly such medication as might increase the activity of epinephrin. This knowledge is important because ordinary dental procedures may produce some emotional stress and cause cardiac disturbances which might be wrongly attributed to epinephrin.

IV. Under these conditions and with these precautions, the use of epinephrin with procaine for dental surgery presents no special hazards in persons with heart disease. We would recommend for any one session that there be used no more than 10.0 cc. of 1:50,000 epinephrin:—no more than 0.2 mgm. of epinephrin in any form.

The Policy and Budget Committee of the New York Heart Association has given approval to the publication of the above report, which the Council considers so important that it deserves wide publicity.

The New York Institute of Clinical Oral Pathology

Connecticut Heart Association, Inc.

Affiliated with American Heart Association
65 Wethersfield Avenue
Hartford 6, Conn.

To the Editor:

June 3, 1955

The Rheumatic Fever Committee of the Connecticut Heart Association has worked out a plan to make available to rheumatic fever patients through their physicians, penicillin at low cost for the prevention of recurrences of rheumatic fever only. This plan has been developed with representatives of retail pharmacists, wholesale druggists and a manufacturer. Upon open bid Bristol Laboratories has been selected as the supplier of penicillin for the program. It has also received the endorsement of the State Medical Society, the State Department of Health and the State Pharmaceutical Association.

This is not a "free" program. It will, however, make penicillin available to patients for prophylaxis at \$3.50 per bottle of 100 tablets—a three months supply. The daily dose will be 250,000 units—within the recommendations of a special committee of the American Heart Association.

Any Connecticut physician who wishes to participate in this program may do so by simply completing and forwarding one application for each patient. Prescription blanks will be sent you by return mail. Please refer to the distribution procedure which follows.

It should be emphasized that this penicillin is for the prevention of recurrences of rheumatic fever only and should not be used for other purposes nor in dosages to exceed one tablet per day. Additional penicillin needed by the rheumatic fever patient for other reasons, temporary or otherwise, must be obtained by him at prevailing retail rates.

Inherent in the program is a system of checks and balances designed to carefully control the distribution and so that a statistical study can be made of the rheumatic fever problem in Connecticut. In addition the procedure will permit a method of determining if and where difficulties are occurring.

Though the program has been designed on a two year service study basis, upon the completion of one year of operation the Rheumatic Fever Committee with the counsel of all concerned will review the entire program to determine its continuation or modification.

For applications or information about the program physicians should call the office of your local Heart Association listed in your telephone directory.

Sincerely,

William J. Lahey, Chairman,
Rheumatic Fever Committee

Distribution Procedure

Rheumatic Fever Prevention Program
Connecticut Heart Association
and

Connecticut Pharmaceutical Association

1. Physicians may apply for the special Heart

Association bottle of penicillin by submitting an application to the Connecticut Heart Association for each patient. Data for statistical purposes is requested on the application.

2. Four coded prescriptions will be sent by return mail to the physician. Each prescription is for one bottle of 100 tablets (3 months supply) of Buffered Potassium Penicillin G 250,000 units (Heart Association). The patient will revisit his physician to get a new prescription every 3 months. (Follow up examination is often recommended at this interval.)

3. The patient will present the prescription to the pharmacist of his choice. The pharmacist will not stock this special bottle. The patient must wait a day or two for the bottle to arrive from the wholesaler.

4. The pharmacist will retain the special prescription and send the stub to the wholesaler. Upon receipt of this stub the wholesaler will send the pharmacist one of these bottles with the pharmacist's next regular stock order.

5. The Connecticut Heart Association will periodically pick up these stubs from the wholesalers. This will serve as a control on distribution and for statistics.

6. Upon receipt of the bottle of penicillin the pharmacist will remove the stock Bristol label and apply his own. The special "For Rheumatic Fever Only" label on the back of the bottle should be left on.

7. The pharmacist will sell the item for \$3.50 per bottle. This represents a savings of \$16.50 per bottle to the patient.

8. Each drug store in the State will be individually contacted by the Heart Association before the program is initiated. If there is materially less than 100 per cent participation a list of participating stores will be issued for the guidance of physicians and patients.

The system to be used provides an automatic month by month check on the distribution. The program will be under the supervision of the Rheumatic Fever Committee of the Connecticut Heart Association working with a committee of the Connecticut Pharmaceutical Association.

FROM OUR EXCHANGES

"Typical and Atypical Electrocardiograms in Myocardial Infarction Caused by Acute Coronary Occlusion and Coronary Insufficiency" is the subject of a discussion of interest by Jaffe (*Dis. of Chest*, XXVII:3, pp. 243-254). Perhaps most medical practitioners, for various reasons, are more interested in the atypical than in the typical electrocardiograms that they encounter in practice. Acute coronary episodes do occur in which the initial electrocardiogram does not indicate a coronary occlusion. Under these circumstances it may be difficult to determine the exact nature of the attack. The electrocardiogram may remain normal for a variable length of time, or may indicate coronary insufficiency and myocardial ischemia. In cases going on to coronary thrombosis and massive infarction the electrocardiogram may show various rapidly changing patterns before the appearance of RS-T elevation and Q waves. In coronary occlusion the electrocardiogram often shows involvement of more than one surface and variations of the typical patterns are frequent.

In acute coronary episodes it is essential to keep the patient at rest until the extent of the myocardial involvement has been determined.

Not infrequently the electrocardiogram shows temporary improvement or actual return of RS-T and T to normal between the third and tenth days after myocardial infarction.

* * * *

Tenney in an interesting discussion of erythroblastosis (*Wis. Med. Jour.*, 54:2, pp. 145-150) makes the following points:

(1) The possibility of the disease occurring should be predicted before delivery by appropriate laboratory methods.

(2) A Coomb's test should be performed at birth to indicate whether the baby has the disease or not.

(3) Other laboratory test measures should be done to evaluate severity.

(4) Exchange transfusion, if this is decided upon, should be executed within the first few hours after the birth, and before the baby appears ill.

(5) Kernicterus may be prevented by early treatment.

According to Tenney it is now generally accepted

that a baby with erythroblastosis should be transfused with Rh negative blood since this type is not affected by the Rh antibodies in the baby's circulation. It was not many years ago that Rh positive blood was advocated in order to neutralize the antibodies present in the baby. This procedure was abandoned because it was found that in the process of neutralizing the antibodies, red blood cells were destroyed, thereby increasing the bilirubin and the jaundice.

Evaluating the severity of the disease when the baby is born presents a problem. Some indication of the severity of the disease can be obtained from physical examination and a blood count. Those babies that are hydropic have a very poor prognosis. Hemorrhagic tendencies also indicate a poor prognosis. There is no indication that babies with a large liver and spleen do poorly.

On the mother's first prenatal visit an Rh determination should be made. If it is her first baby and no transfusions have been done she can be told not to worry, for it is rare to have the first baby affected. If she has been transfused in the past or if she has been pregnant before, antibody titers should be made at the time of her first visit to determine "carry-over" antibodies (previous sensitization). If she has no antibodies it is safe to wait until near the end of the pregnancy before obtaining another determination. If she still has no antibodies the chances are excellent that the baby will be unaffected. If she has antibodies present at the first determination then they should be followed at regular one- to two-month intervals to note the rise or fall of antibodies.

Dr. Tenney is of the opinion that if one has an idea from the maternal history and level of antibodies that the baby may have trouble, it is wise to begin laboratory procedures at once (if necessary within one or two hours after birth). It is better to begin treatment at once and not wait until the baby becomes jaundiced before doing tests to determine the cause.

* * * *

Tetanus is still a pediatric problem in some areas. Jenkins and Beach in six years at the Medical College of South Carolina saw 21 cases of tetanus (*Jour.*

So. Car. Med. Assoc., LI:3, pp. 66-71). In most instances their treatment included one intramuscular injection of 50,000 to 100,000 units of antitoxin. The mortality rate was 21 per cent in cases of tetanus occurring in children from ages 1 to 14 and 57 per cent in cases of tetanus neonatorum. None of the patients in their series had received adequate immunization against tetanus. There seemed to be no typical wound associated with tetanus, although puncture wounds are usually considered to be the type most commonly associated with the disease.

* * * *

Postural shock in pregnancy is a commonly overlooked situation owing to the fact that the symptoms are promptly relieved by a change from the dorsal recumbent position. According to Wilkening and Larson the difficulty usually occurs in late pregnancy and is apparently due to compression of the vena cava by the flaccid, near term, pregnant uterus (*Cal. Med.*, 82:3, pp. 159-166).

The feature of the supine hypotensive syndrome can be duplicated by applying pressure to the abdomen with the patient in a lateral position. When shock is observed in a woman in late pregnancy, she should be changed to a lateral position before more active measures of treatment are begun.

* * * *

Determining the site of brain tumors is often a difficult problem. Amyes and Vogel discuss the use of radioactive iodine and phosphorus as an aid in locating brain tumors (*Cal. Med.*, 82:3, pp. 167-170).

The site of the tumor was correctly determined in 61 per cent of 39 cases of tumors of the cerebral hemispheres by tests using radioactive iodine combined with diodofluorescein. In 19 cases where the focal radioactivity was increased 24 per cent or more over that of the surrounding area, there were no errors in location. Fifteen patients with expanding intracranial lesions were tested at operation with radioactive phosphorus and 14 lesions were correctly localized. This procedure in which the needle probe was used was found to be of great value in rapidly locating and outlining the area of involvement.

* * * *

Indications for cardiac surgery are listed by O'Neil (*Wis. Med. Jour.*, 54:2, pp. 137-144) as mitral stenosis, pulmonic stenosis, aortic stenosis,

tricuspid stenosis, mitral insufficiency, aortic insufficiency, atrial septal defect, ventricular septal defect, coronary thrombosis, angina pectoris and certain combined lesions.

Most important for a successful outcome is correct diagnosis. New diagnostic methods permit a high degree of accuracy in determining the lesion, its size, composition, relation to surrounding tissues and its location. Another important factor is the age of the patient. Complications of the cardiac disorder itself and other diseases change the prognosis. The probable outcomes with and without surgery must be carefully weighed.

The author does not consider congenital heart lesions, except as they occur in his list of possible operational conditions. Dr. O'Neil points out that a potentially vast new surgical field has been opened during the past few years, providing cures for many types of cardiac defects and amelioration for others. He predicts, in the light of recent experimental data, that in the near future, reasonable solutions will be found for the unsolvable problems of the moment.

* * * *

McCarthy, in an effort to develop a new approach to the definitive palliation of patients with advanced cancer, treated 100 cases with large doses of ACTH or cortisone administered simultaneously with nitrogen mustard. The majority of the patients were in advanced or terminal phases of cancer and had failed to respond successfully to previous surgical, radiation or hormone therapy (*New Eng. Jour. Med.*, 252:12, pp. 467-475).

Temporary remissions for intervals as long as three years were obtained in 16 per cent of the patients. An additional 15 per cent received good palliation, with prolongation of life in increased comfort. The remaining 69 patients were classed as fair (29 per cent) or poor (40 per cent) in palliative response and received little or no benefit.

The ACTH and cortisone successfully acted to abolish or greatly to reduce the severe nausea, vomiting and bone-marrow depression usually caused by nitrogen mustard. Complications and side effects were few and temporary.

The author suggests that there is evidence that the use of the method in earlier phases of cancer, its concurrent employment with radiation and triethylene melanine, as well as recent refinements in technic, will produce palliation and remissions superior to those reported in this series.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Newell W. Giles, Darien

President-Elect, Mrs. Norman J. Barker, Collinsville

First Vice-President, Mrs. J. ALFRED WILSON, Meriden

Second Vice-President, Mrs. Frank L. Polito, Torrington

Recording Secretary, Mrs. Charles Culotta, Hamden

Corresponding Secretary, Mrs. C. Murray Gratz, Cos Cob

Treasurer, Mrs. Joseph Woodward, New London



MRS. F. ERWIN TRACY

Mrs. F. Erwin Tracy of Middlesex County has been elected Chairman, Public Relations Committee of the Woman's Auxiliary to the AMA. From 1953-55 she has been co-chairman of the Eastern Regional Membership Committee. From 1952-53 she was 3rd vice president of National.

Her work for the medical auxiliaries has been on county and State as well as national levels. She was a charter member of her county organization and later its president. She held six offices in the State, including that of president.

She was twice elected to the presidency of the Middletown Branch of the American Association of University Women and at one time was vice

president of the Connecticut branch. She has been a trustee of Middletown's Russell Library since 1942. In 1948 she became a director of the Middletown District Nurse Association and continued in that position until this year. She has been president of the Middletown Garden Club since 1954. For four years she served her church as secretary of the Parsonage Building Committee.

This biography does not include all the work that Mrs. Tracy has done in her community. It simply highlights her career thus far and indicates the diversification of her interests and abilities.

She is the mother of two sons, one a senior at Harvard College, the other a student at Choate School.

County News

HARTFORD

Hartford County closed its season with an annual meeting at the Wampanoag Country Club. Dr. Vernon Lippard, dean of the Yale School of Medicine, spoke on "Current Problems in Medical Education." The following officers were elected: President Elect, Mrs. John D. O'Connell; First Vice President, Mrs. Nicholas Marinaro; Second Vice President, Mrs. Isidore S. Geeter; Recording Secretary, Mrs. John C. Allen; Corresponding Secretary, Mrs. James A. Hanaghan; Treasurer, Mrs. Joseph N. Russo; Assistant Treasurer, Mrs. Stewart P. Seigle. Mrs. Charles N. Sullivan assumed the office of president.

FAIRFIELD

Election of officers took place at the annual meeting in April. The slate included: Mrs. Charles Sheard, president; Mrs. Robert Nespor, president elect; Mrs. John D. Booth, vice president; Mrs. R. Glen Wiggins, Jr., recording secretary; Mrs. Fritz Meyer, treasurer; Mrs. Norman Jarvik, corresponding secretary.

Guest speaker for the afternoon was Mrs. April

Oursler Armstrong, author, daughter of the late Fulton Oursler.

The following delegates to the AMA Convention were appointed: Mrs. George Geanurocos, Mrs. Ellwood Weise and Mrs. Robert Nespor, alternate.

LITCHFIELD

Litchfield County's tenth anniversary was celebrated with an all day clambake June 26 at the cottage of Dr. and Mrs. I. S. Goldberg on Highland Lake, Winsted. The committee responsible for this affair was: Mrs. Louis E. Garston, chairman; Mrs. J. H. Kott, Mrs. A. Orlowski, Mrs. I. S. Goldberg, Mrs. N. Samponaro, Mrs. F. Ursone and Mrs. D. Samson.

New officers for the coming year are: President, Mrs. Winfield E. Wight; President Elect, Mrs. J. Henry Kott; Vice President, Mrs. Daniel P. Samson; Secretary, Mrs. Royal A. Meyers; Treasurer, Mrs. Louis E. Garston.

MIDDLESEX

A May board meeting was held to plan for next year's activities. A Membership Tea will be held September 27 and will be combined with a hobby show.

Mrs. Clarence Harwood and Mrs. F. Erwin Tracy were delegates to the AMA Convention.

Following is the slate of officers for 1955-56: President, Mrs. Louis Soreff; President Elect, Mrs. Joseph Epstein; Vice President, Mrs. William Bauer; Secretary, Mrs. Norman Gardner; Treasurer, Mrs. Sanford Harvey.

NEW HAVEN

Following is the slate of officers for the coming year: President, Mrs. J. David McGaughey, 3rd; President Elect, Mrs. Charles Culotta; Vice President, Mrs. Christopher Dwyer; Recording Secretary, Mrs. Henry Caplan; Corresponding Secretary, Mrs. M. Walter Radowiecki; Treasurer, Mrs. Gustaf Lindskog.

NEW LONDON

The following officers were elected at the annual meeting: President, Mrs. Hugh F. Lena, Jr.; Secretary, Mrs. James Harkins; Corresponding Secretary, Mrs. George Kennedy; Treasurer, Mrs. David Rousseau; Assistant Treasurer, Mrs. Anthony Loiacono.

Guest speaker at the luncheon was Mr. Donald Shepard, librarian of the Submarine Base at Groton. He spoke on "The Nautilus."

WINDHAM

Two nursing scholarships are to be awarded this year. Janet Marie Peckham of North Grosvenordale and Sybil Christine Compa will enter Hartford Hospital in September.

Officers for the coming year are: President, Mrs. Winston C. Hainsworth; President Elect, Mrs. John Woodworth; Secretary, Mrs. James W. Major; Treasurer, Mrs. Karl Phillips.

Professional Policy Committee Election

The winners of the first direct election of Connecticut Medical Service Participating Physicians for appointment to the CMS Professional Policy Committee are Benjamin V. White, M.D., West Hartford; Edward R. Howe, M.D., West Hartford, and Edward J. Ottenheimer, M.D., Windham Center.

Drs. White, Howe and Ottenheimer were nominated for the election by their county medical associations. In all, the names of 16 physician nominees appeared on the ballots mailed to the CMS Participating Physicians, as directed by an amendment to the CMS By-Laws, voted at the 1955 annual meeting of the Board of Directors.

The CMS Professional Policy Committee now is comprised of 12 practicing physicians and is unique in the insurance field in Connecticut, giving CMS members the advantage of the guidance of practicing physicians in the adjudication of problem situations which arise in claims pending for CMS surgical-medical coverage. The members of the Committee meet monthly and serve voluntarily without pay or remuneration of any kind.

Thomas J. Danaher, Torrington, is chairman of the Committee, as well as vice-president of CMS.

Also newly appointed to the Committee by virtue of their office, as provided in the By-Laws amendment, are Oliver L. Stringfield of Stamford, president of the Connecticut State Medical Society, and Ralph T. Ogden, West Hartford, president-elect of the State Society.

Nominated by the Council of the State Society and appointed by the CMS Board of Directors are: Henry A. Archambault, Norwich; Orpheus J. Bizzozero, Waterbury; Thomas Feeney, West Hartford; Robert G. Reynolds, West Hartford; Walter I. Russell, New Haven, and Edward J. Whalen, West Hartford.

ANNUAL REPORTS

OF THE CONNECTICUT STATE MEDICAL SOCIETY

1954-1955

REPORT OF THE COMMITTEE ON HOSPITALS AS AMENDED BY THE REFERENCE COM- MITTEE AND APPROVED BY THE HOUSE OF DELEGATES APRIL 26, 1955

The Committee on Hospitals of the Connecticut State Medical Society held several meetings which were largely devoted to the discussion of hospital-physician relationship. The discussions mostly concerned those physicians who practice radiology, anesthesiology, pathology and physiatry but it was considered that the principle involved was applicable to all physicians who practice for a salary in a hospital which charges and collects fees for their professional services, and wherein the salary paid the physician has no basic relationship to the professional fees collected by the institution.

The Committee is of the opinion that the adequacy of a salary received by a physician for professional services rendered has no bearing on the principle involved, and that the preservation of the private practice of medicine would be more assured if the income of all physicians practicing in private hospitals was in direct relationship to fees charged for their services, provided that the patient, the physician and the hospital are not exploited.

The past, the present and the future influence of Connecticut Hospital Service on the practice of medicine was also considered and the committee supported previous actions of the Connecticut State Medical Society that Connecticut Hospital Service should not provide for medical services and should not pay hospitals for professional services rendered by physicians. It was contended that there is as much reason for Connecticut Medical Service to provide for hospital services and pay the physician for them as for Connecticut Hospital Service to include medical services in the contract and pay the hospital for them.

The Hospital Committee felt that these vexing problems and differences of opinion would remain static unless the Connecticut State Medical Society, the Connecticut Medical Service, the Connecticut Hospital Service, and the Connecticut Hospital Association could get together and negotiate a mutually satisfactory solution. It was planned to ask for meetings with representatives of these organizations for this purpose, but before these meetings were requested the committee considered that a legal opinion on the corporate practice of medicine in Connecticut was necessary or nothing more would be accomplished than had been possible by previous committees and that this committee would end up as had all others with little or no progress. The Council of the Connecticut State Medical Society was therefore asked to obtain this opinion from the Attorney General of

Connecticut "through whatever channels it seemed proper to obtain such an opinion." They obtained it through the Connecticut Medical Examining Board and it has been published in the CONNECTICUT STATE MEDICAL JOURNAL, which is concluded as follows:

"It is therefore our opinion that nonprofit, charitable hospitals are not violating the provisions of the statutes concerning the illegal practice of medicine or surgery when they employ full-time paid specialists, who are licensed physicians, to conduct necessary tests and perform services in the treatment of patients at the hospitals."

A study of the opinion suggests that the Attorney General may not have had knowledge of certain facts essential to a proper and full understanding of the question and the Hospital Committee therefore feels that the opinion is unrealistic, inconclusive and subject to other interpretation. The question as to whether it is legal for a corporation of laymen to employ a physician to practice medicine, which charges the public a fee for his professional services, collects the fee for the profit of the corporation and pays the physician a salary which bears no relationship to the fees collected, is still not answered. There is no indication that consideration was given to a decision by the Supreme Court of Errors which is relative to another profession but which may have a bearing on the principle involved, "that an optometrist may not lawfully engage in the practice as an employee of a corporation which bills the patient for services rendered by the optometrist and where the optometrist is paid a regular salary plus commission by the corporation." A clear distinction is not made between charitable hospitals in which fees for professional medical services are not charged, and nonprofit hospitals in which fees for professional medical services are customarily charged.

The opinion defines a hospital as "an institution for the lodging, care and treatment of persons suffering from disease, or abnormal physical condition" and it indicates that a hospital may "practice medicine by means of its staff" but it does not indicate that a hospital can not be licensed to practice medicine.

The inference that the law of restriction applies only to commercial corporations and not hospitals is debatable and the reference to recent legislation allowing "the formation of corporations to conduct medical clinics under certain safeguards" refers to the Medical Group Clinic legislation which allows the formation of non-stock corporations whose members are duly licensed physicians. This legislation provides that the corporation "may not itself give medical or surgical treatment, consultation or advice" and "only persons licensed pursuant to Section 16600 and no others may be members of such corporations." It would seem that if

corporations of laymen may legally practice medicine through employed physicians, the Medical Clinic legislation is really surplusage.

The reference to interns and residents as a precedent would suggest that the Attorney General may not have been informed that hospitals do not make a separate or specific charge to patients for the service of residents and interns, that they may or may not be licensed, that their professional work is under the direction and supervision of the staff physicians and not the hospital and that the interns assist staff physicians in the care and treatment of their patients which are hospitalized.

The Hospital Committee is of the opinion that a hospital is a place or institution where medicine is practiced by physicians, that hospitals should provide nursing care and furnish facilities for diagnosis and treatment of the sick by physicians, that diagnosis is as much the practice of medicine as is the treatment of disease, that the right to practice medicine is a personal privilege that cannot be delegated, that the financial interest of an institution should not be injected between the physician and the patient, that a corporation of laymen may employ physicians to practice medicine on a purely charitable basis but that it is contrary to the existing laws relating to the practice of medicine in Connecticut for a lay corporation to sell the services of a physician to the public on a fee basis for the profit of the corporation.

The Hospital Committee of the Connecticut State Medical Society therefore feels that the opinion of the Attorney General relative to the corporate practice of medicine in Connecticut may have been given without his having before him all the essential facts and background, and for the sake of the record the Hospital Committee recommends that the Connecticut State Medical Society, through proper channels, present all the facts before the present Attorney General and respectfully request that he review the opinion of his predecessor. The Committee also recommends that the Attorney General be requested to give an opinion on the following specific questions:

1. Can a nonprofit hospital or other corporation, group or association of laymen be licensed to practice medicine and treat the sick in Connecticut for a fee?
2. Are existing laws relating to the practice of medicine in Connecticut violated if a licensed physician enters into a contract with a nonprofit hospital wherein the physician renders medical services for a salary, and wherein the hospital bills the patient and collects fees for those services for the profit of the hospital?

If the Attorney General agrees to answer the questions and to review the opinion of his predecessor, the council shall be directed to confer with the Connecticut Hospital Association, Connecticut Medical Service and Connecticut Hospital Service in an attempt to negotiate a mutually amicable solution and present all pertinent facts to the Attorney General for his consideration.

Respectfully submitted,
Ralph T. Ogden

REPORT OF THE COMMITTEE ON NATIONAL LEGISLATION

D. Olan Meeker, Chairman

Frank H. Couch

Henry Merriman

Thomas M. Feeney

Charles T. Schechtman

Joseph A. Fiorito

Edward P. White

Executive Secretary

Chairman, Committee on State Legislation

During the second session of the 83rd Congress much was done from the standpoint of the medical profession. The constructive record of that Congress in medical matters is in large degree a tribute to officers of state associations and individual physicians who have taken the time, trouble and expense to keep in touch with their Senators and Representatives.

There were 16,470 bills and resolutions introduced in the two sessions of the 83rd Congress, of which 407 were of interest to the medical profession.

The only major part of the Eisenhower health program opposed by the AMA was the reinsurance legislation.

Social Security

HR 9366 Social Security Amendments of 1954 was passed by the Senate August 13 and later signed by the President. The new bill extends coverage, increases benefits and taxes, liberalizes the retirement test, and maintains benefit levels of the disabled. Physicians and other self employed professional persons were excluded, but the President's recommendation on the method of waiving OASI premiums for the permanently disabled was adopted.

Hill-Burton Program

The 1946 Hill-Burton Construction Act was expanded to permit the federal government to spend \$182 million in three years to help finance the construction of the new nonprofit facilities. Congress previously in 1953 extended the life of the Hill-Burton Act to 1960.

The expanded Hill-Burton construction program, signed by the President on August 27, will have \$21 million available for the next year for construction grants.

The \$21 million was earmarked by Congress as follows: hospitals for chronically ill, \$6.5 million; diagnostic treatment centers, \$6.5 million; nursing homes, \$4 million; rehabilitation centers, \$4 million.

In its closing days, Congress also approved supplemental funds for the Department of Health, Education, and Welfare to carry out other expanded programs voted earlier in the session. They included \$4 million for State grants under the new vocational rehabilitation law; \$5 million for administering the broadened social security program, and \$1 million for water and air testing studies for the Civil Defense Administration.

Vocational Rehabilitation

The new law gives states more assistance and responsibility for rehabilitation programs in an attempt to increase from 60,000 to 200,000 by 1959 the number of disabled persons

rehabilitated yearly. It also provides for special training for rehabilitation specialists, increased research on conditions that result in handicaps, and new benefits for the blind.

Health Reinsurance

The Health reinsurance proposal was defeated. The AMA opposed this bill because voluntary health insurance is still growing at a phenomenal rate without government intervention, the need for such intervention had not been shown, and the bill did nothing to help individuals presently not insurable. Although reported out by both House and Senate committees, its firm defeat on the floor of the House marked the end of the proposal.

Public Health Service Grants

The Administration bill to streamline Public Health Service grants was passed by the House but failed in the Senate to progress beyond the hearing stage.

Omnibus Tax Revision Law

In completely rewriting the federal tax laws for the first time in 75 years, Congress lowered the medical expense tax deduction from 5 per cent to 3 per cent, doubled the maximum limitation on deductions, and liberalized other health and drug tax features.

Other Medical Bills

Other measures of medical interest which became law during the 83rd Congress included: (a) the transfer of the Indian hospital and medical service from the Indian Bureau of the Department of the Interior to the Public Health Service of the Department of Health, Education, and Welfare; (b) a federal charter for the National Fund for Medical Education; (c) prohibiting the shipment of fireworks into a state where their sale is illegal; (d) extending the doctor draft act to 1955 and strengthening the Defense Department's position in dealing with physicians and dentists who might be security risks.

Dr. Walter B. Martin, President of the AMA wrote in one of his monthly messages the following:

"There are those who maintain that physicians have no place in the arena of political action but that they should quietly continue to practice their profession and leave to our elected representatives the responsibility of making legislative decisions affecting medicine. There are others who contend that organized medicine should not engage in such activities and charge that our organizations are not representative of American medicine. Nothing could be further from the truth. The physician has not only the normal concern that every citizen should have for his government and its actions but also the responsibility for making a critical analysis of proposals in the areas of his special knowledge."

"Bills have been or will be produced bearing on many aspects of medicine."

"I would urge all physicians to study them and to be prepared to form judgment and to exercise their privilege of supporting or opposing them. Conclusions should be reached on the basis of the broad, general impact of such legislation, not on the basis of its effect on any one segment of our population or its political implications."

With the convening of the 84th Congress on January 5, 1955 there was a revival of several bills from the 83rd Congress. Prominent were the Bricker resolution, the federal health reinsurance plan, expansion of medical aid for military dependents, private pension tax deductions, health insurance for federal employees, mortgage insurance, traineeships of nurses and other professional personnel, revision of public health grants and a bigger mental health program.

Other bills include extension of water pollution control, grants for mothers, crippled children, etc., better medical care for the indigent, a new attack on juvenile delinquency and extension of the Doctor Draft.

The medical profession is placed in another precarious position through the provisions of the expanded Hill-Burton Act—now Public Law 482—enacted last year by the 83rd Congress.

The Law provides for the establishment of diagnostic and treatment centers, the dream-scheme of the International Labor Organization and other socialistic bodies for herding all citizens into "centers" for assembly-line medical care by panels of salaried doctors.

The Iowa State Medical Society was the first state organization to recognize the real dangers in "diagnostic and treatment centers."

The Executive Council of the Iowa State Medical Society in a bulletin dated January 26, 1955, stated: "The Executive Council gave careful study to the program for the establishment of diagnostic or treatment centers and came to the conclusion it had to reject this program for the following reasons:

"1. It has found no evidence of any need for additional diagnostic or treatment services for ambulatory patients.

"2. To the best of its knowledge, such diagnosis and treatment facilities are available to all Iowans regardless of ability to pay.

"3. Traditionally, diagnosis and treatment of ambulatory patients is carried out in the private offices of physicians where the personal relationship of the patient to his family physician can be maintained.

"4. On the other hand, the establishment of hospital diagnostic treatment clinics, where patients would be assigned by number to any available doctor, would eliminate the free choice of physician.

"5. When the personal relationship between the patient and the physician of his choice does not exist, the quality of medical care suffers. When a physician works in a hospital clinic on a salary, he must obey the individual who controls the purse strings, and the patient's interests become of secondary importance. The world over it has been observed time and time again that when the doctor-patient relationship is destroyed, the quality of medical care deteriorates.

"6. The proposal to establish hospital diagnostic-treatment clinics is but another form of socialized medicine wherein the hospital, financed by the government, will assume the dominant role in diagnosing and treating illness, not necessarily according to the individual needs of the patient or the judgment of the physician, but through ad-

herence to federal rules and regulations dictated out of the Department of HEW."

Now that diagnostic and treatment centers are provided for in the federal law, the only way to stop the creation of this additional setup for socialized medicine is through the state Legislatures. Legislation to implement the program at the state level and to provide state matching funds, should be opposed vigorously.

The Board of Trustees of the American Medical Association issued a statement commending President Eisenhower for his January 31 health message to Congress and has pledged continued support to improve the health of the nation by strengthening medical efforts at the state and local levels. The Board congratulated Mr. Eisenhower on his statement that health proposals to the 84th Congress "recognize the primacy of local and state responsibility" and would "encourage private efforts with private funds."

"The AMA has been in complete accord with the stated purpose of legislation designed to promote voluntary health insurance and commends Mr. Eisenhower for his beliefs and efforts in encouraging its expansion. The medical profession has been reassured to find that the official position of the government is one of "trust and confidence" in the ability of private initiative to solve existing problems in the field of medical care. However, the AMA still believes that the proposed reinsurance system will not achieve the desired results."

Senator Bricker again proposed his constitutional amendment, which would: (1) prohibit treaties made in conflict with the Constitution, (2) make a treaty ineffective as internal law without legislation that would be valid without the treaty, and (3) require a roll call vote for ratification. The amendment resolution lost last year in the Senate, but a one-vote shift would have given it the required two-thirds. The medical profession is interested in the amendment because under present law socialized medicine could be imposed through international treaty or agreement without being considered by the House and Senate. The U.S. Supreme Court has under advisement a case (*U.S. vs. Guy W. Capps*) that could have an important bearing on the problem. The case concerns an Executive agreement between the U.S. and Canada.

On February 28, 1955 the Hoover Commission on Federal Medical Activities submitted its report to Congress. This report had somewhat the same effect as a small nuclear bomb would create if dropped on the House floor.

The Hoover commission has cast an expert eye over the medical activities of the federal government and has brought forth a report sustaining previous suspicions that the more than 4 billion dollars spent on these activities include some hundreds of millions of waste and duplication.

Although the veterans administration is authorized by law to give treatment for nonservice connected disabilities only if the veteran is unable to pay for private treatment, little effort is made to determine whether declarations of inability to pay are truthful.

The American Medical Association objects that the remedy of closer audits proposed by the commission has already been tried and doesn't work. It regrets that the commission rejected the recommendation of its own medical task force that free care for nonservice connected ailments be cut off three years after a man is discharged from active service.

Merchant seamen, the commission notes, are among the most highly paid groups in the nation's economy, but the public health service still gives them free medical care and maintains for them the dozen hospitals (one in Chicago) that were provided when seamen shipped for a few dollars a month.

The veterans administration has too many hospitals. Many of these, it has been previously disclosed, were placed by congressional logrollers in remote communities where it is impossible to hire and retain competent medical and nursing staffs.

At the same time the army, navy, and air force continue their individual, merry ways in conducting their medical affairs, as if unification of forces had never been decreed by congress.

The commission recommends that 19 VA hospitals, nine military hospitals, and nine military infirmaries be closed or put to civilian use because they are "obviously marginal" to federal needs. The building of veterans' hospitals is a long standing evil. The failure of the presumably unified defense forces to organize a common medical system is shocking. The commission urges that the services pool their medical facilities, with the possible result that the army would handle all medical work in one area and the navy in another.

This report is going to put the good faith of Congress to a severe test. Most of the wasteful evils that the commission denounces have been recognized for years. They exist primarily because of congressional pork barrel politics. Will the congressmen now have the courage to undo what they have done in order to save an estimated 300 million dollars a year or more? They certainly should not be spared the test.

The commission's recommendations on tightening up of veterans benefits drew strong protests from American Legion National Commander Seaborn P. Collins and the Legion's National Rehabilitation Commission. A unanimously adopted commission resolution expressed "great shock, disappointment and disapproval of these unfounded, uneconomic and heartless recommendations."

In closing, your Committee again wishes to thank the Council of the Connecticut State Medical Society for its approbation. Dr. Creighton Barker, as usual, has done yeoman duty in helping us.

Your Chairman wishes to thank those members of the Committee who attended the Hartford Meeting on November 15, 1954 to meet with Dr. Frank Wilson, the Director of the Washington Office of the American Medical Association.

Respectfully submitted,

D. Olan Meeker

REPORT OF THE COMMITTEE ON THIRD PARTY PAYMENTS

Henry A. Archambault, Chairman

Donald G. Arnault
Thomas M. Feeney

Russell A. Keddy
Walter I. Russell

During the year there was only one meeting held, on February 1, 1955, at which time a few small matters were presented to the Committee and which were satisfactorily solved.

The Standing Committee of the Society has been fairly inactive this year because at the House of Delegates Meeting in 1954, a Special Committee had been appointed to study Third Party Payments for medical and ancillary non-surgical services and owing to the overlapping and duplication of effort, it was not deemed advisable for the Standing Committee to interfere with the program of the Special Committee.

However, it would seem to the members of the Standing Committee that after the report of the Special Committee is presented to the House of Delegates and accepted, then probably, the functions of that Special Committee could be taken over by the Standing Committee on Third Party Payments.

Respectfully submitted,
Henry A. Archambault

REPORT OF THE COMMITTEE ON STATE BLOOD BANK

Ralph E. Kendall, Chairman

Irving B. Akerson
Gerald J. Carroll
Joseph O. Collins
Frederick B. Hartman
Louis P. Hastings
Christie E. McLeod

Sawyer E. Medbury
Lincoln Oppen
Charles H. Peckham
Karl T. Phillips
Victor G. H. Wallace
Levin Waters

Ira Hiscock, *Associate Member*

After close to five years of the Connecticut Regional Blood Program the hospitals of the state continue to be supplied with blood at close to the highest rate of any area in the United States. During the past year, blood was furnished by the C.R.B.P. in excess of 12 pints per active short stay hospital bed. This contrasts sharply with 7 pints reported recently to the New England Blood Bank Association by the hospitals of Massachusetts. It is equally striking that the largest user in Massachusetts, 10 pints per occupied bed is below our average of 12 pints. It is hazardous to infer that this points to a wastage of blood in Connecticut. It would seem rather that the inadequate supply has limited the Massachusetts usage. Certainly numerous blood volume studies substantiate this conclusion that over-transfusion is a rare observation.

These figures vividly point out the outstanding job of donor procurement the Connecticut chapters of the Red

Cross have done and continue to do. It is unfortunate that there still remains a small number of laggard areas within the state and the Committee is directing its attention to these defections.

The program faces within the coming year a serious financial problem brought about by the withdrawal of the National Red Cross subsidy amounting to nearly fifty per cent of the total cost. The extremely low unit collecting and processing cost of \$4.60 speaks not only of the operational efficiency but also recognizes the large number of volunteer man hours contributed by the local Red Cross Chapter. It becomes clear however that the withdrawal of National Headquarters subsidy is fully justified when it is realized that only 30% of the United States have a significant program and Connecticut cannot expect to receive funds from those areas that do not benefit from the program. Unfortunately the only solution seems to be to put part of these costs back on the patient and members of this Committee are serving on a Liaison Committee with members from the Connecticut Hospital Association and Red Cross for the purpose of resolving these difficulties.

An answer to the recurring problem of hepatitis has not as yet been found. A detailed file of all cases reported has been maintained at the Center; however, to date no chronic carrier has been revealed through this study. Studies on useless transfusions have been undertaken by Dr. Rosahn and Dr. McLeod. No action has been taken by the Committee to extend this to the entire state.

Donor procurement continues as a major problem, particularly the obtaining of new donors. The members of the Medical Society must embrace every opportunity to give to their local Red Cross workers support in enlarging the donor pool. It must be emphasized however again that this must be done in closest cooperation with the local chapters since wildcat solicitation though with the best of intentions, can often lead to confusion rather than to assistance.

Your Committee would be remiss to close this report without extending to Dr. Wallace, Medical Director, our appreciation for his work in bringing C.R.B.P. to the high degree of success that it has attained.

Respectfully submitted,
Ralph E. Kendall

REPORT OF THE COMMITTEE TO STUDY MATERNAL MORTALITY AND MORBIDITY

Carl E. Johnson, Chairman

Eric H. Blank
Lewis P. James
Bernard F. Mann, Jr.
Norman C. Margolius
Hugh K. Miller
Jessie E. Parkinson

Charles H. Peckham
A. Rocke Robertson
W. Leslie Smith
Hoyt C. Taylor
Archibald W. Thomson, Jr.
Stanley B. Weld

The Committee to Study Maternal Mortality and Morbidity of the Connecticut State Medical Society held seven

regular meetings during 1954, all of which were well attended.

The provisional maternal mortality rate for 1954 is 3.0 per 10,000 live births.

Total number of cases reviewed.....	21
Non-maternal causes	6
Maternal causes	15

There were no deaths from either maternal or non-maternal causes during the months of September and December.

The program for making fibrinogen available to hospitals has been continued and the supply of fibrinogen available to Connecticut hospitals has increased.

The Subcommittee on Toxemia of the Committee to Study Maternal Mortality and Morbidity had three meetings during 1954, at which severe cases of toxemia were discussed in detail. The material for discussion was obtained from the forms which had been prepared by the Subcommittee on Toxemia and which had been distributed to each maternity hospital in Connecticut by the Connecticut State Department of Health, with the request that a form be completed for each diagnosed case of toxemia and that the completed form be forwarded to the Connecticut State Department of Health. Twenty-seven of the thirty-six maternity hospitals in Connecticut have completed forms, thus supplying the committee with cases for discussion and data on the incidence of toxemia in Connecticut. With forms for the last quarter of 1954 still being received, there have been reported to date 497 cases of toxemia for 1954, 73 of which were severe toxemias. There were 5 deaths due to toxemia of pregnancy in 1954. From their review of cases and intensive study of the problem of toxemia, the members of the subcommittee are preparing recommendations for the prevention and treatment of toxemia complicating pregnancy. These recommendations will be published in a future issue of the Connecticut State Medical Journal.

During the year 1954 there has been a close working relationship between the Committee on Neonatal Mortality and the Committee to Study Maternal Mortality and Morbidity in an effort to find ways for improving care to mothers and their newborn infants. An increasing number of cases of neonatal mortality are being discussed by both committees.

Two obstetricians from a neighboring state attended one of the monthly meetings of the committee to observe its modus operandi, with the intention of forming a similar committee to study maternal mortality and morbidity in their state.

In October 1954, Elizabeth C. Wells retired as Maternal and Child Hygiene Physician for the Connecticut State Department of Health. Dr. Wells served as a member of this Committee from its inception and made a great contribution to the work of the Committee and to the present high level of obstetrical care given to Connecticut patients. Jessie E. Parkinson has succeeded her in this important work.

Respectfully submitted,
Carl E. Johnson

REPORT OF THE MEDICAL ADVISORY
COMMITTEE TO THE STATE WELFARE
DEPARTMENT

Edwin R. Connors, Chairman	
Ettore F. Carniglia	Leonard Parente
Mark A. Gildea	J. Harold Root
Maxwell Lear	Edwin F. Trautman
Henry Louderbough	William H. Upson
Donald R. Morrison	Harold D. VonGlahn

This committee has met on nine occasions since its appointment by the Council of the State Society in April of 1954. Its work has been facilitated by the presence of a voting majority at every meeting, and by the prompt completion of individual assignments by each member concerned. On the Committee's invitation, Dr. Harold F. Pierce, Medical Director of the State Welfare Department, has attended all meetings, serving as consultant in matters related to the State's medical care of the indigent.

The Committee was fortunate in having its members representative of various fields of medicine, specialists as well as general practitioners, and of being able to draw upon the advice, counsel and experience of many members of the Society as well.

The Committee's most important and time consuming task has been the revision of the fee schedule issued by the Commissioner of Finance and Control in 1951, which governs payment to medical practitioners by all institutions, departments and agencies of the State.

The changes advised and noted below are not radical, the intent being to bring the provisions of the schedule up to date and to simplify its procedures, while adjusting its fees to comply with the State's policy expressed in the following considerations:

1. To furnish adequate medical care for the maintenance of health.
2. The satisfactory and prompt remuneration to those rendering these services.
3. That services are rendered to medically indigent patients and should be at a lower rate than that expected from patients of average income.
4. That remuneration for services rendered should be computed on a uniform basis for all agencies and such fees cover only actual medical need in each case on the most economical basis consistent with professional fulfillment of such need.

The following recommendations for revision of the fee schedule were made by the committee:

- The deletion from the entire schedule of the Unit System.
- The payment under Schedule One of \$4.00 for a home visit.
- To include in Schedule One; under physical examination, complete; a blood for serology, when such a procedure is indicated in the opinion of the physician.
- The deletion of; the examination to determine eligibility for Aid to the Blind; in Schedule Three.
- In Schedule Three; the inclusion of, measurement of tension in examination of the eyes with refraction and the

fee for examination of eyes with refraction and measurement of tension to be, \$10.00 in the office and \$11.00 when done at home.

Deletion of; Electroshock, Metrazol, or Insulin Therapy, in Schedule Three; as not being an office procedure.

The addition to Schedule Three of; Clinical Psychological examination with I.Q. determination at a fee of \$5.00.

Under Schedule Three; to the fee for electrocardiogram with interpretation; when done in the home, add the fee for one house call.

Under Schedule Four; the payment for surgical procedures performed in the office should be based on 80% of the fee paid by Connecticut Medical Service on a Standard Contract.

The use of the laboratory of the State Department of Laboratories for necessary examinations, whenever possible, under Schedule Five.

Clarification of procedures in Schedule Five as follows:

Analysis of Urinary Calculus; to replace calculus.

Urinalysis, routine and microscopic; to replace, Urinalysis.

Pregnancy tests, to be listed; Pregnancy test, animal, at a fee of \$3.00.

The deletion of; Bone Marrow examination, as not being an office procedure; in Schedule Five.

Under Schedule Five; the addition of the following:

Sickle Cell examination at a fee of \$3.00.

Determination of Protein Bound Iodine at a fee of \$10.

The deletions of the following procedures under Schedule Five: under Chemistry;

Sulfonamide.

Thiocyanates.

Urea Clearance.

Total Protein, Cu or drop method.

Under Bacteriology, in Schedule Five; deletion of; auto-genous vaccine.

Under Schedule Five, Miscellaneous; the addition of the following:

Radioactive Iodine Uptake at a fee of \$10.

Scotch tape test for infestation of pin worms at a fee of \$1.

Under Schedule Seven; Tinting of lenses at a fee of \$1.10 per lens, only on the prescription of an ophthalmologist who shall state the definite clinical indication for same.

The basis for change in lenses, under Schedule Seven; a change in vision of 0.50 sphere or 0.50 cylinder, but not both.

The recommendation of armor plating of lenses for children, under Schedule Seven, at \$1.50 per lens.

The Committee recommended to the Welfare Department, the use of adrenocortical stimulating hormones by physicians, without prior arrangement and authorization.

It was recommended that X-ray and Radium therapy be administered only by certified Radiologists and Dermatologists.

The Committee advised the procurement of prior ar-

range and authorization by practitioners, for routine X-ray examinations and routine laboratory examinations, such examinations to be done only after such permission has been given.

The use of sera and vaccines, supplied by the State Department of Health, and which can be secured from the local Director of Health, without cost, should always be used for beneficiaries of the state welfare program.

The use of clinics and outpatient departments of hospitals, was recommended by the committee to be used by beneficiaries, at the discretion of the physician.

The Committee recommends the use of oral medication, in the care of beneficiaries, whenever practicable. In hormonal therapy, oral medication should be used, in the opinion of the committee, in preference to parenteral hormonal therapy and conservatively as suggested by the Council on Pharmacy of the American Medical Association.

The Committee recommends that each practitioner become acquainted with the Revision of the Pharmacy Program of the Welfare Department, issued on January 1, 1955, as it applies to beneficiaries of the state welfare program and also with the statutes of the state establishing this state welfare program as it applies to practitioners of the medical arts, and the opinion of the Attorney General of the State of Connecticut, which opinion has the force of law.

The recommendations of the committee for revision of the Fee Schedule have been made to the Medical Affairs Reference Committee for its consideration, and thereafter, for presentation to the Commissioner of Finance and Control of the State of Connecticut for his approval, publication, and issuance to each practitioner of the medical arts of the State of Connecticut.

Respectfully submitted,

Edwin R. Connors

REPORT OF THE DELEGATE TO THE CONNECTICUT NUTRITION COUNCIL

The Council held seven meetings in 1954. At the January 13 meeting Dr. Potgeiter stated that information on Nutrition Education had been prepared for elementary teachers in the Virgin Islands. Plans were then held for a state wide meeting in the interest of nutrition education for February 2, 1954.

The Connecticut Nutrition Council sponsored a state wide meeting in the interest of Nutrition Education grades 1-9 at the Hockanum School, East Hartford, Connecticut, on Tuesday, February 2 from 3:30-8:30. The Council first attempted to reach every elementary school in Connecticut to discover interest in such a program and to collect ideas for the development of a program to meet the needs of the classroom teacher. This was done through Bulletin Board Announcements and Questionnaires sent to all elementary schools through superintendents offices. From this the details of a program including exhibits, inspirational address, demonstrations of promising practices, standard "school lunch" supper and group dynamic discussion were arranged. About 275 grade school principals and elementary

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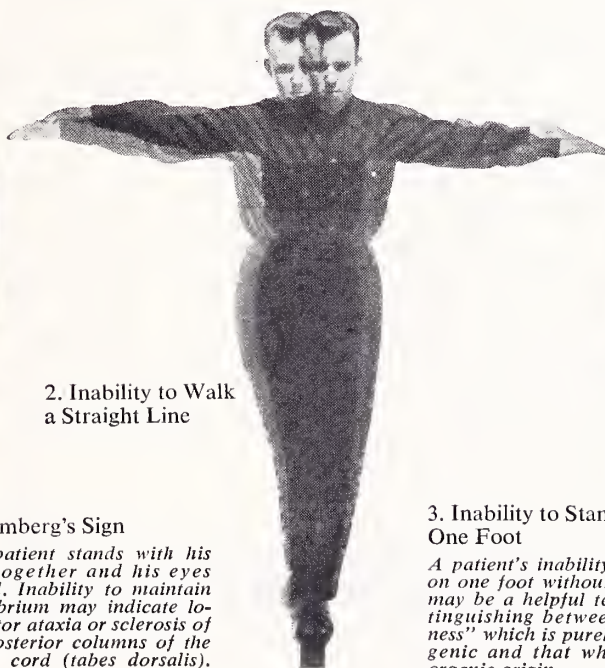
Notes on the Diagnosis and Management of "Dizziness"

II. False Dizziness



1. Romberg's Sign

The patient stands with his feet together and his eyes closed. Inability to maintain equilibrium may indicate locomotor ataxia or sclerosis of the posterior columns of the spinal cord (tabes dorsalis).



2. Inability to Walk a Straight Line



3. Inability to Stand on One Foot

A patient's inability to stand on one foot without lurching may be a helpful test in distinguishing between "dizziness" which is purely psychogenic and that which is of organic origin.

False dizziness is a sensation of sinking or lightheadedness which is often of psychogenic origin. It should be distinguished from true "dizziness" or vertigo¹ in which there is a definite whirling, moving sensation.

Unsteadiness, lightheadedness and similar manifestations of false dizziness² may be psychogenic or the result of arteriosclerosis, hypoglycemia, drug sensitivity and general metabolic disturbances such as anemia and malnutrition. Hypertension is often the cause of these symptoms.

Psychogenic dizziness probably originates at the highest brain centers. It may be described as a sense of uncertainty with occasional mild lurching but not to the point of falling. In these patients there is no nausea, no disturbance of vestibular pathways and otologic and neurologic examinations are negative. The sensation is unaffected by head movement. Symptoms usually disappear³ with complete rest.

Dramamine® has been found highly effective in many of the conditions already mentioned. Maintenance therapy with Dramamine will often keep the patient from becoming incapacitated by his condition.

Dramamine is also a standard for the management of motion sickness and is useful for relief of nausea and vomiting of fenestration procedures and radiation sickness and for relief of "true dizziness" of other disorders.

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1. Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP 8:35 (Nov.) 1953.

2. DeWeese, D. D.: Symposium: Medical Management of Dizziness. The Importance of Accurate Diagnosis, Tr. Am. Acad. Ophth. 58:694 (Sept.-Oct.) 1954.

3. Kunkle, E. C.: Central Causes of Vertigo, J. South Carolina M. A. 50:161 (June) 1954.

SEARLE

teachers, homemaking teachers; school lunch personnel; school nurses; public health nurses; college home economists; extension workers; representatives of State Departments of Education, Health and Welfare and members of the Connecticut Nutrition Council attended. An evaluation of the registration showed that 57% attending were interested in teaching technique and 65% with the health of the school child.

Guests were greeted with tomato juice, cranberry juice, crackers and cheese and fancy sandwiches upon arrival. Members of the Council were invited to exhibit so that quantities of free nutrition material were distributed and sources of additional material available. A chick experiment suitable to elementary school classroom work was one of the most interesting exhibits. Seventh grade homemaking class work of balanced tray meals also showed correlation for industrial arts boys who made the trays.

At the opening meeting Dr. George Cowgill, Nutritionist, Yale University and Chairman of the Council, presided and introduced Mrs. Katherine Wisely, Area Home Economist U. S. Department of Agriculture, who spoke on "The Twelve O'Clock Scholar" and showed the correlation of all classroom teaching with the school lunch program. Following this an opportunity to choose your own interest by grades grouped the conference for demonstrations of promising practices. Group I, the Habit Forming Years; Group II, To Grow Alert; Group III, Food Becomes You, and Group IV, the Family Feeds Its Children.

The supper was part of the learning experiences for hostesses from the Council and from the East Hartford schools helped to make this a sociable experience enjoying a Grade A lunch. Following this Miss Ruth C. Cowles, Consultant, Home Economics Education, State Department of Education, led a discussion period bringing about participation of all through buzz sessions to formulate questions answered by a Panel of Experts from the Nutrition Council.

The meeting closed with a good note of appreciation to the Council and the desire for another meeting in another part of the state. The evaluation showed that 51 different towns were represented and that the objectives were met namely: to arouse interest in nutrition instruction, to give positive help for classroom experiences, to make available pertinent material, to give new facts and review basic facts and to show at least one useful promising practice.

At the February 24 meeting it was felt that an annual meeting of this type should be beneficial to the promotion of nutrition education. A report of this meeting was prepared for the inter-agency committee of the Federal Government while a request for a report was received from the Health Commissioner of Minnesota.

At the April 7 meeting Chairman Cowgill reported a request from the Connecticut Advisory Committee on School Health to participate with this group.

On May 19, Dr. George R. Cowgill, Professor of Nutrition at Yale University presented a combination Health Talk and Travelogue entitled "Nutrition and Public Health Problems of the Orient."

On August 4, the Council Chairmen met and agreed that we should support the Connecticut Public Health Association's fall meeting in which "The Importance of Nutrition

for Good Health" was to be the topic. The Council also discussed the formation of a speaker's bureau and offered its services to any member organization which needed a speaker on some phase of nutrition at its main or annual meeting. The Council also offered to the teacher's colleges its aid in setting up and staffing a practical course in the area of child welfare, growth and development.

On October 13, William H. Adolph, PH.D., Lecturer in Nutrition and Public Health, Yale University School of Medicine, spoke on Nutrition in the Orient.

On November 17, plans were made for a meeting of the Council and guests at Centinel Hall of G. Fox and Co., Hartford on January 26, 1955. The subject was to be "Eating for Health in Connecticut."

The work of the Connecticut Nutrition Council is extremely important and I would urge the Connecticut State Medical Society to continue to send a delegate to its meetings.

Respectfully submitted,
Max Caplan

REPORT OF THE COMMITTEE ON STUDENT MEMBERS

William E. Bloomer, Chairman

William F. Bauer, Jr.	Morris P. Pitock
Nathaniel Kenigsberg	Alan K. Poole
William H. Lohman	Arthur C. Unsworth

John B. Wells

Executive Secretary of the Society

Since my appointment to the Committee on Student Members, I have been attempting to find in what way this committee can best serve the student interests. I have interviewed a number of students for their opinions as well as some faculty members, including Dean Lippard.

All were quite appreciative of the help and interest which has already been given by the Medical Society—especially with regard to the provision of a certain number of scholarships and the sponsoring with the Department of Public Health of the series of lectures on the Economics of Medical Practice.

After sampling opinions among the students here, I am inclined to believe that the series of lectures on the Economics of Medical Practice embracing as it does problems of entering practice, physician-patient relationships, third party relationships, and types of medical practice and given by men outside the academic field does provide what has been obviously needed in the past. Beyond this, I have found no further suggestions as to needs that the students have. Moreover, Dean Lippard tells me that the Committee on Cooperation between the Medical Society and the University, which I understand has been formed recently, has proved to be a fine means of keeping the society and the school in close touch.

In light of these facts, I really believe that this committee's original function has been largely supplied by other means, and I suggest its dissolution.

Respectfully submitted,
William E. Bloomer

REPORT OF THE COMMITTEE ON EMERGENCY
MEDICAL SERVICE

Benjamin B. Whitcomb, Chairman

Alfred L. Burgdorf	William B. Smith
Luca E. Celentano	C. Frederick Yeager
Carl C. Chase	James C. Hart
Franklin M. Goodchild	Mrs. Helen Cullen
Ralph E. Kendall	Mr. Stuart W. Knox
Edward H. Kirschbaum	Frederic S. Harold, D.D.S.
Mr. Felix Blanc	

There have been no formal meetings of the Committee on Emergency Medical Service since the last committee report. Members of your committee, however, have worked with offices of the State Department of Civil Defense in an advisory capacity and have cooperated with Dr. Prout, the Medical Director of the State Department of Civil Defense, in the organization of the program to be given in the Section on Civil Defense at this annual meeting of the society which we hope will prove helpful to all members of the society. The drastic changes in the destructive power of potential military weapons have brought about extensive changes in civil defense planning so that it has not been possible to inform your committee of the exact duties of the members of the society in case of major disaster.

Respectfully submitted,
Benjamin B. Whitcomb

REPORT OF THE CONFERENCE COMMITTEE
WITH THE CONNECTICUT STATE DENTAL
ASSOCIATION

Edward T. Wakeman, Chairman

David J. Cohen	Camille H. Huvelle
Cornelius S. Conklin	Brae Rafferty

This committee is appointed to be the conference group with the State Dental Association and to discuss with that group problems of mutual interest to the two professions and bring the professions into closer relationship in all fields.

There have been four meetings since last report. The first of these was arranged as a joint meeting with the State Bar Association. Dr. George Gildersleeve, then President of the Medical Society, presided. Dr. Cyrus H. Maxwell of the Washington Office of the American Medical Association discussed proposals for the extension of social security to cover self-employed professional groups, and the pending Jenkins-Keogh legislation to permit tax deductible contributions to voluntary retirement and pension plans for self-employed persons.

Mr. David M. Richman, Chairman of the Social Security Committee of the New Haven County Bar Association explained clearly why it would not be to the advantage of self-employed professionals to be included under the provisions of the Social Security laws. He urged that doctors and lawyers give their active support in favor of the Jen-

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kins-Keogh bill. This provides the self-employed professional an opportunity to save for old age and retirement out of current income. Mr. Richman's remarks have been published in a brief and lucid article in the May 1954 issue of the Connecticut State Medical Journal.

The second meeting, held June 8, was addressed by Dr. Francis J. Ryan, Chief Medical Officer, and Dr. Forrest D. Patriquin, Chief of Dental Service, of the Veteran's Administration in Connecticut. They gave a clear exposition of the functions of their departments in the care of veterans on an out-patient basis. The Committee felt that they were serving a real need and were exercising reasonable care not to extend treatment beyond service-connected disabilities.

On October 12 the problems of malpractice insurance were discussed by Mr. C. H. Olson, Superintendent of the Professional Liability Department of the Aetna Casualty Company, and by Mr. Bernard S. Quigley, an attorney with Aetna. Improperly kept records, or lack of them, poor practice management or patient relationship, and careless conversation with patients were stressed as frequently responsible for malpractice suits. The increased cost of business, larger legal fees and larger settlements or jury awards explain the high cost of malpractice insurance. It was felt that there should be an educational effort in the interest of prevention.

The December meeting considered the need in Connecticut for a well-coordinated rehabilitation program for patients with cleft palate deformities. Guest speakers were Dr. Louis Spekter of the State Health Department, Dr. Morton Loeb, dentist, and Dr. Norton Canfield, otologist.

Dr. Spekter outlined the magnitude of the problem. He estimated that there are about 800 cases of cleft palate under twenty-one years of age in Connecticut with an increment of about 50 new cases each year. About one fourth of these are known to the Division of Crippled Children.

Dr. Loeb described the rehabilitation programs of various clinics including the Lancaster Clinic in Pennsylvania and the clinic at the University of Illinois in Chicago. These clinics have clearly demonstrated the value of coordinated effort by the plastic surgeon, orthodontist, pediatrician, dentist, social worker, psychologist, speech clinician, prosthodontist, and many others.

Dr. Canfield spoke from experience in establishing rehabilitation centers for the hard of hearing after the war. Many of the specialized services necessary for rehabilitation of the deaf are also necessary for the rehabilitation of the cleft palate cases. He stressed the need for a rehabilitation center in Connecticut which will bring together many special skills in a well-integrated program for evaluation and treatment of all defects of communication.

The Combined Conference Committee has made recommendation to the State Medical and State Dental Societies that this need be recognized and appropriate action be taken.

Respectfully submitted,
Edward T. Wakeman

REPORT OF THE COMMITTEE TO STUDY
NEONATAL MORTALITY

John W. Buckley, Chairman

William K. Bannister	Louis Guss
Ronald S. Beckett	Winston C. Hainsworth
Martha L. Clifford	Clarence W. Harwood
David J. Cohen	Charles A. Murphy
Joseph A. Fiorito	Albert U. Peacock
Charles H. Peckham	

This Committee has met approximately every six weeks. The function of the Committee is to study infant mortality in the State of Connecticut, and, obviously, this does not permit the study of every infant death. Therefore, the cases have been selected on a chance basis that has been recommended by the statisticians of the State Health Department. The Committee is composed of Pediatricians, Obstetricians, and an Anesthesiologist and a Pathologist, all of whom have made definite contributions to the Committee's work.

The chief results of the work of the Committee have been:

(1) The education of the individual members of the Committee, all of whom feel that they have personally learned something from the discussions of these infant deaths;

(2) The increased awareness of the problems of neonatal mortality throughout the State. As a result of the formation of this State Committee, many hospitals throughout the State have been aided in setting up their own joint committees to study neonatal mortality.

It has been found, though not to our surprise, that our chief source of mortality is in the premature group, and that most of the deaths occurred in the first twenty-four hours of life. To reduce this mortality substantially will require more than the complete use of our existing clinical facilities and resources.

Within the year, it is hoped that a statistical survey of neonatal mortality in Connecticut will be available for publication in the State *Journal*.

Respectfully submitted,
John W. Buckley

REPORT OF SPECIAL COMMITTEE TO STUDY
THIRD PARTY PAYMENTS FOR MEDICAL AND
ANCILLARY NON-SURGICAL SERVICES

Benjamin V. White, Chairman

Richard I. Barstow	David G. Rousseau
Joseph J. Bowen, Jr.	Michael S. Shea
Roy C. Ferguson	Louis Soreff
Ralph L. Gilman	Harold E. Speight
Roswell B. Johnson	Morris Sulman
Benjamin Katzin	R. Bruce Thayer, Jr.
Neil Lebhar	Jacques Van B. Voris

John A. Woodworth

In accordance with a resolution adopted by the House of Delegates at its Annual Meeting on April 27, 1954, the President of each county society appointed two men repre-

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Bumbalo, T. S., Gustina, F. J.,
and Oleksiak, R. E.:
J. Pediat. 44:386, 1954.

White, R. H. R., and
Standen, O. D.:
Brit. M. J. 2:755, 1953.

against **ROUNDWORMS**

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Brown, H. W.:
J. Pediat. 45:419, 1954.

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senting the "various non-surgical components of medicine to explore the whole matter of fair remuneration of medical and ancillary non-surgical services." At the organization meeting on July 15, 1954, Dr. Benjamin V. White of Hartford was elected Chairman and Dr. Joseph J. Bowen of Waterbury, Recorder. At this meeting a wide range of topics was introduced for consideration. The action which has been taken with regard to each is included in the Committee's recommendations which appear below.

A second meeting of the Committee was held on September 23, 1954. At this time it was voted to table for future consideration a number of problems, including fees for physicians practicing anesthesiology, surgical assistants fees, payments by the State Welfare Department, and fees for X-ray work carried out in hospital out-patients departments. The Committee then adopted with minor editorial changes a statement of principles for non-surgical practitioners in dealing with purveyors of third party payments which had already been adopted by the Medical Division of the Hartford Hospital and by a Special Committee of Non-Surgical Practitioners appointed by the Hartford County Medical Society. (The paragraphs concerned solely with the State Welfare Department were tabled for later consideration.) It was agreed that the problems presented by C.M.S. were of the most immediate concern and the subsequent discussion centered about fundamental issues involved. Among other things it was decided that the first three days of hospital care and medical consultations could be left uninsured for the present. It was also concluded that it would be preferable to have limited medical coverage within the regu-

lar premium structure than more extensive coverage on a rider which might prove difficult to sell. It was further agreed that, if adequate insurance for basic medical care could be provided it would be of secondary importance to cover such ancillary procedures as thoracentesis, liver biopsy, lumbar puncture, etc.

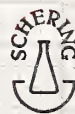
At a third meeting of the Committee on October 7, 1954, considerable attention was given to the problem of combined care of the post-operative surgical patient. There is a trend in some States toward covering medical services by withholding a part of the surgical fee. However, a survey in Hartford County indicated that the average non-surgical practitioner makes a charge for medical care during post-operative convalescence in only ten percent of his cases referred for surgery. With this information it seemed realistic to recommend that medical care during the first few post-operative days be rendered on a consultation basis. The committee then concluded that no plan proposed by C.M.S. should be recommended to the House of Delegates as satisfactory if it made it embarrassing for a non-surgical practitioner to collect \$50 for the first week of hospitalization, \$35 for each of the second and third weeks, and \$35 for a major medical consultation whether rendered in one or more visits.

On October 20, 1954, a subcommittee discussed with representatives of C.M.S. ways and means by which the goals set forth above might be achieved. It is obvious from data available that the addition of extensive new services would require rewriting the contracts at higher premium levels or the addition of riders.

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CONCLUSIONS

The following conclusions are oriented in terms of major problems confronting patients in their professional relations with various types of non-surgical practitioners. These conclusions attempt to furnish, in accordance with the policies adopted by this Committee, practical solutions which should not be beyond the financial means of C.M.S.

A. *Basic Medical Care.*

1. *During the second and third weeks of hospitalization.* The only practical solution within current insurance practice is payment of at least \$5 per day during this period.

2. *During the first week of hospitalization.* Payments could be handled in a number of ways from complete exclusion to complete coverage provided that no plan should make it embarrassing for a physician to collect \$50 for the first week. Five dollars per day from the fourth through the seventh days would be acceptable. However, the public relations of C.M.S. would be greatly enhanced by more adequate coverage. (See paragraph E below.)

B. *Consultations.*

For the present, medical consultations should be excluded. However, the recommendations of the Joint Commission on Accreditation of Hospitals with regard to more widespread use of consultants warrant consideration of some type of coverage for consultations in the not distant future.

C. *Combined Care of the Postoperative Patient.*

Necessary medical care during the first few postoperative days should be furnished on a consultation basis at the expense of the subscriber. Medical coverage should recommence immediately after the expiration of the average uncomplicated hospital stay following each of the various surgical procedures.

D. *Procedures and Technics.*

A limited number of time consuming or hazardous procedures and technics should be covered in a special category which eliminates the twenty-one day period of after care (exchange transfusion, cardiac catheterization, etc.). Advertising and promotional literature for the present and contracts when revised should make clear that all other procedures and technics are uncovered (unless embraced under the "bitter with the sweet" principle described in paragraph E below).

E. *The First Three Days, Time Consuming Cases, Etc.*

1. From the viewpoint of the physician the payment of \$5 per day beginning on the fourth day would be an acceptable solution to these problems, but it must be recognized that in many cases the patient would be charged for the first three days a fee which would be grossly disproportionate to that made subsequently.

2. A preferable solution would be to pay \$7 per day from the fourth through the seventh days to obviate the necessity for such disproportionate charges.

3. A still better solution, from the viewpoints of the subscriber and of C.M.S. would be to pay \$7 per day for the third through ninth hospital days for the full professional services of a physician including minor technics on the "bitter with the sweet" principle. If the "bitter with

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the sweet" principle were adopted, the physician would agree on service benefit cases to accept \$7 per day from the patient as full payment for the first and second days.

RECOMMENDATIONS

The principles set forth in the narrative report and the conclusions elaborated above were discussed at a Joint meeting with the Professional Policy Committee of C.M.S. on March 3, 1955. As a result of the deliberations at that meeting the following specific recommendations are made as initial steps in achieving the desired goals.

1. That C.M.S. be requested to increase in-hospital daily benefits in the Preferred contract from \$4 per day to \$5 per day.

2. Disapproval of \$3 per diem in-hospital daily benefits on existing Standard Contract. However, in view of obligations incurred by C.M.S., adjustment of the medical benefits may be postponed until the contract is revised.

3. That C.M.S. be requested to give early attention to coverage for the sick newborn and the premature infant.

4. That C.M.S. study the possibility of offering at a later date on a rider at extra premium the following forms of medical coverage: procedures and techniques otherwise not covered, psychotherapeutic interviews, and consultations, presumably on a deductible basis.

5. That the present Committee be continued as a Special Committee of the House of Delegates with the following specifically assigned duties:

a. To study and make recommendation on matters which have been tabled for future consideration.

b. To prepare in carefully edited form a set of principles for non-surgical practitioners in dealing with all purveyors of third party payments.

c. To review progress on the present recommendations and to report to the House of Delegates at the Semi-annual meeting in December, 1955, and at the next annual meeting.

Respectfully submitted,

Benjamin V. White, Chairman
Joseph J. Bowen, Recorder

REPORT OF COMMITTEE ON CONNECTICUT HEALTH LEAGUE

Luther K. Musselman, Chairman

Elisabeth C. Adams

Frederick L. Nichols

The Connecticut Health League is composed, at present, of 39 agencies, all of whom are interested in various phases of the health and welfare of our citizens. The membership totals about 145.

As reported in the *Journal*, the Connecticut Health League held a two day meeting in April, 1954, at Rocky Hill; at which time, various problems associated with aging were discussed. Some phases of this subject have been considered more in detail at the semi-annual and annual meetings.

Respectfully submitted,
Luther K. Musselman

REPORT OF THE CONFERENCE COMMITTEE WITH THE STATE BAR ASSOCIATION

George H. Gildersleeve, Chairman

Andrew J. Jackson

Sidney Shindell

H. M. Marvin

Oliver L. Stringfield

At the time of writing this report no meetings of this committee have been held. There have been informal conferences between members of each committee, and it was felt that a regular meeting should be postponed until a problem for discussion arose.

A meeting will be held in March or April in order to discuss pertinent legislative measures and problems.

Respectfully submitted,
George H. Gildersleeve

REPORT OF THE CONFERENCE COMMITTEE WITH THE AMERICAN LEGION

George H. Gildersleeve, Chairman

Egbert M. Andrews

Samuel B. Rentsch

Norton Canfield

Stanley B. Weld

The Conference Committee with the American Legion held no meetings during the past year as there were no important problems for discussion.

Respectfully submitted,
George H. Gildersleeve

SPECIAL NOTICES

21st NEW ENGLAND HEALTH INSTITUTE "Lighthouses in a Changing World"

Following is a thumb-nail sketch of events planned by our Maine colleagues to satisfy all health interests—and fun, too, during the Institute sessions August 30, 31 and September 1, 1955 at Colby College, Waterville, Maine.

THE PROGRAM

Opening Meeting—8:00 P. M., TUESDAY, AUGUST 30, 1955
(No registration will be required of those attending this meeting only)

Welcome: The Honorable Edmund S. Muskie, Governor
Speaker: O. Spurgeon English, M.D., Head, Department of Psychiatry, Temple University Medical School
Subject: "Lighthouses In A Changing World"

WEDNESDAY, AUGUST 31, 1955

Morning: Three general sessions—outstanding speakers

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Office Equipment and Furniture For Sale. Doctor is leaving practice to specialize. Equipment is little used. Included are portable x-ray, basal metabolism, new diathermy, examining table, refrigerator, and many other items. Phone: STate 7-3784 9-10 A. M. or 6-8 P. M.

FOR SALE—FCC approved, Raytheon Microtherm; condition good as new; asking price one-half of original cost; Dr. J. P. Goodridge, 11 Asylum Street, Hartford.

Afternoon: Ten panels—simultaneously conducted

Subject: "Through Prevention and Rehabilitation To Optimal Health"

(Here are some of the exciting panel subjects planned, with leaders eminent in the field:)

Local Health Services

Changing Patterns in Family Life

Human Relations in Public Health

Teamwork in Rehabilitation

A New Look At Tuberculosis Control

Accident Prevention

Juvenile Delinquency

Prevention and Rehabilitation As Applied To Housing

Prevention in Dentistry

Prevention of Radioactive Contamination of Water and Aquatic Life

THURSDAY, SEPTEMBER 1, 1955

Morning: Three general sessions

"The Job Ahead"—

"Thinking About it"

"Planning For It"

"Acting To Meet It"

Afternoon: Institute Summary

INTERNATIONAL FERTILITY ASSOCIATION

October 6-8, 1955. Toronto, Canada. The Canadian Society for the Study of Sterility, Secretary: Dr. Earl

Plunkett, 469 Waterloo Street, London, Ontario, Canada.

October 8-10, 1955. Zaragoza, Spain. Sociedad Espanola para el Estudio de la Esterilidad. Symposium: "Exploration de la Funcion del Ovario en la Esterilidad." Presidente: Prof. J. Botella Llusia, Velazquez, 83, Madrid, Spain.

This meeting is divided as follows:

1. Clinical methods to recognize and estimate ovarian function.
2. Vaginal cytology and its diagnostic value.
3. Endometrial biopsy and its diagnostic value.
4. Hormonal tests and their scientific value.
5. Tests for ovulation.

October 24-29, 1955. Buenos Aires, Argentina. International Fertility Association. Round table discussion of fertility problems in connection with the Congreso de Obstetricia Gynecologia de Buenos Aires. Secretary, Dr. Pedro A. Figueroa Casas, Rosario, Argentina.

December 10-11, 1955. Chicago, Illinois. International Fertility Association. This meeting will be devoted to an evaluation of diagnostic and therapeutic methods and agents. It will consist of several formal presentations and round table discussions for the purpose of providing the practicing physician a clearer insight into these problems, such as the timing of the endometrium, estrogens in sterility, the diagnostic methods with cervical mucus, methods of semen appraisal, the value of thyroid administration, nutritive douches and many other items in common clinical use which deserve better clinical appraisal. Details of this meeting will be announced in the forthcoming issue of *Fertility*.

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For further information and reservations, communicate with Paul Topkins, M.D., Associate U. S. National Secretary, International Fertility Association, 1141 Eastern Parkway, Brooklyn, New York.

May 18-26, 1956. Naples, Italy. International Fertility Association, Second World Congress on Fertility and Sterility. Chairman of Arrangements Committee: Professor G. Tesaro, Naples, Italy.

THE SEVENTH AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY

Will be held from March 25-29, 1957, at the Palmer House, Chicago, Illinois.

A WORKSHOP IN MEDICAL WRITING

To be held on the second day of the twelfth annual meeting of the American Medical Writers' Association under the instruction of members of the journalism faculties of the University of Illinois, University of Missouri and University of Oklahoma, Saturday, October 1, 1955, 8:00 A. M. to 12:00 noon, Hotel Jefferson, St. Louis, Missouri.

From First Draft to Printed Article, Dr. Paul Fisher, School of Journalism, University of Missouri.

Specific Devices for Increasing the Readership of Medical Articles, Professor Stewart Herral, School of Journalism, University of Oklahoma.

Writing Magazine Articles for the Lay Reader, Theodore Peterson, Assistant Professor, School of Journalism and Communications, University of Illinois.

Those who wish to attend are asked to enroll at the Registration Desk. There is no charge for the workshop to members of A.M.W.A. For others the fee is \$5. In order to keep classes small, enrollees will be divided into three groups of approximately equal size and each instructor will give his material three times. At the end of each recess (see below) members of each group will pass to a new room and will meet a new instructor. Division into groups will be made, and rooms will be announced, at the general assembly (see below).

Those who intend to enroll are invited, well in advance of the meeting, to send manuscripts of popular medical articles they may have on hand to Theodore Peterson, assistant professor, School of Journalism and Communications, University of Illinois, Urbana, Illinois. He will criticize some of these manuscripts at the workshop.

TIME SCHEDULE

- 8:00 to 8:10 — general assembly
- 8:10 to 9:20 — first work period
- 9:20 to 9:30 — recess
- 9:30 to 10:40 — second work period
- 10:45 to 10:50 — recess
- 10:50 to 12:00 — third work period

Coordinator: Richard M. Hewitt, M.D., Rochester, Minnesota.

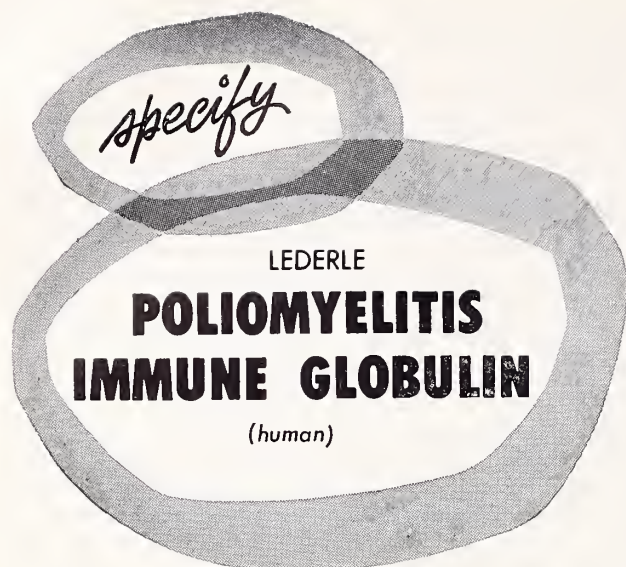
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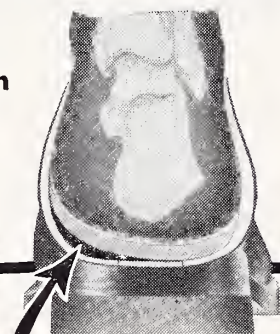
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B. 1. SPECIAL CLINICS (BY APPOINTMENT)

2. A. Cerebral Palsy Thursday 1:00 P. M.
B. Plastic Surgery Last Friday of month 2:30 P. M.
C. Muscular Dystrophy Monday 9:30 A. M.
D. Neurology Last Wednesday of month 3:00 P. M.
Speech, Occupational and Physical Therapy by appointment.

3. & 4. Eligibility and fees based entirely on ability to pay.

OUR NEIGHBORS

New Hampshire and Vermont

The 142nd Annual Meeting of the Vermont State Medical Society will be another joint Annual Meeting with the New Hampshire Medical Society at the Mount Washington Hotel, Bretton Woods, New Hampshire, on Friday and Saturday, September 30 and October 1, 1955.

Maine

W. Mayo Payson, Esq., for the past eight years executive secretary of the Maine Medical Association, has resigned his position with the Association. In his place Daniel F. Hanley, M.D., physician to Bowdoin College, has been appointed to the newly created post of director of the Association. Dr. Hanley is a member of the staff of the Mercy Hospital in Portland and the Bath Memorial Hospital in Bath. Before his appointment as college physician at Bowdoin he served two years in the U. S. Army Medical Corps in the China-Burma-India theatre.

NEWS

from County Associations

Fairfield

Twenty-nine two-men teams are competing for honors in the Fairfield County Medical Golf Association tournament which opened in May with a qualifying round. Actual play started in June, with matches scheduled for this month, August and September in various courses in Fairfield County.

D. Olan Meeker, Riverside, is president of the golfing physicians' groups and Edwin F. Trautman, Trumbull, secretary-treasurer.

Halsey G. Bullen, Stamford, has been appointed to the Public Relations Committee by President Nathaniel Selleck. Other members of the groups, all reappointed, are: Milton M. David Deren, Edwin R. Connors, Bridgeport; Louis Rogol, Danbury; Frederick W. Finn, Greenwich; E. Tremain Bradley, Norwalk; D. Olan Meeker, Riverside.

Members of the American Medical Education Foundation Committee, the establishment of which was authorized on a county level at the annual meeting in April, are Newell W. Giles, Stamford; John W. Jovell, Danbury; Robert A. Northrop, Norwalk. Their appointments were made by President Selleck.

Hartford

Howard Boyd of Manchester was elected president of the Hezekiah Beardsley Pediatric Club at its annual meeting in April. Dr Boyd has been chief of the pediatric department of the Manchester Memorial Hospital since the department was formed 20 years ago and has been a practising physician in Manchester for 31 years.

Harry C. Clifton, one of Hartford's leading surgeons during the first half of this century, died at his home in Bloomfield on May 24.

Middlesex

Robert Gordon, who has been in charge of the Intern Training Program at the Middlesex Memorial Hospital for several years, left on July 1. His successor is Seymour Lipsky of the Department of Medicine, Yale Medical School.

William Sweeney has moved to New York City where he has a full time appointment on the faculty of Cornell Medical College and on the staff of New York Hospital.

Jerome Kirschbaum has moved to 311 Main Street, Portland where he will continue in general practice.

Joseph Epstein is at Roosevelt Hospital in New York City. He is the resident on the Allergy Service.

A case report, "Serum Sickness Manifested by Anterior Chamber Exudate" by Mark Thumim, was published in the May issue of the *AMA Archives of Ophthalmology*.

New Haven

At the recent monthly meeting of the New Haven County Medical Association held in Waterbury, Harry J. Stettbacher was its guest. Dr. Stettbacher was a past president of the New Haven County Medical Association. He is retiring from active practice to Maryland. Dr. Stettbacher was active as attending urologist at the St. Mary's and Waterbury Hospitals for many years.

John M. Freiheit received a first prize June 8 from American Physicians Art Association for a portrait of Dr. A. Nowell Creadick, retired associate professor of medicine at Yale University. The prize was awarded at the association's annual exhibit-contest displayed in Atlantic City, New Jersey.

New London

James W. Sayre announces the opening of his office for the practice of pediatrics at 280 Montauk Avenue, New London.

The June meeting of the New London County Medical Association was held on the 2nd at Uncas-on-Thames. The guest speaker was William Schwartz from the New England Medical Center Hospital in Boston. He spoke on "The Practical Aspects of Fluid and Electrolyte Balance." A dinner at the Norwich Inn preceded the scientific session.

The annual outing of the New London City Medical Society was held Saturday, June 11, at Edge Lee Point, South Lyme. The attractions consisted of a clam chowder lunch, golf at the Old Lyme Country Club, swimming, soft ball, and a beef barbecue in the evening.

At the annual dinner meeting of the Norwich City Medical Society held June 8, at the Norwich Inn, plans for improvements to the W. W. Backus Hospital were discussed, and new committees were formed for the coming year.

Merrill Grayson, formerly of 183 Williams Street, has recently been discharged from the Air Force after serving two years in England where he was

consulting ophthalmologist for United States Forces located in England. He enjoyed the traveling, but reports that it is better to be at home. Dr. Grayson is now going to become associated with Dr. John Gager and the two of them plan to open a joint office in the Lena Hospital on Broad Street in the near future. Joseph Ganey, Jr., left New London and reported back to the Air Force on June 20. Major Ganey has received orders to report to Otis Field on Cape Cod.

It has also been reported that among the travelers in our Society, Joseph Mahoney is presently en route on a trip to Ireland.

New Haven

Harold Broady of Meriden has been certified as a Fellow of the American Academy of Obstetrics and Gynecology.

Windham

Sidney Vernon of Willimantic presented a paper on "Ground Substance and Surgical Diseases of Connective Tissue" at the meeting of the International College of Surgeons held in Geneva, Switzerland in May.

NEW BOOKS IN REVIEW

MANAGEMENT OF ADDICTIONS. Edited by Edward Podolsky, M.D. New York: Philosophical Library, Inc. 1955. 413 pp. \$7.50.

Reviewed by JOHN DONNELLY

This volume is a collection of papers already published in various journals by a number of authorities interested in problems of alcohol and drug addiction. The book is divided into two sections, one dealing with alcohol, the other with drugs and because the factors responsible for both types of addiction are essentially similar, there is much repetition in the second section of the material already covered in the first.

One may find here articles representing the opinions of all concerned with these problems including the psychodynamic, endocrinological, the conditioned reflex, sedative, nutritional, etc., approaches. One of the important limitations arises because of frequent repetition from article to article, a limitation which is inherent in any collection of papers by different authors on the same topic. The volume is not planned to bring these viewpoints into perspective one with the other.

As a collection of papers dealing with specific approaches, it is an interesting collection, but it does emphasize the widely divergent opinions which exist as to etiology and treatment of these social problems. One is left with even the more disappointing awareness of the narrowness of attack by workers who are concerned only with single aspects of a complex subject.

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MEDIASTINAL TERATOMA

Rare Case in a Mentally Sick Patient and a Review of Hypotheses of Genesis

HANNAH PIERSON, M.D., *Norwich*

EVER since Rudolf Virchow¹ published his paper on a teratoma myomatodes and called attention to the importance of investigating the teratomata "Wundergeschwuelste" emphasizing the immense scientific value and information that may be obtained from them concerning the problems of the genesis of tumors, their development and growth, these fascinating and puzzling tumors have become the object of intense study.

The growth with which we are concerned in this paper is a thymic teratoma of the mediastinum which was found in a mentally sick patient, aged 25.

Mediastinal congenital tumors are rare growths; only 245 cases have been reported up to 1945 in the epidermoid, dermoid and teratoma group.² Smith and Stone³ report an incidence of only 108 cases of mediastinal dermoids and teratomata.

Hedblom's² classification divides the congenital intrathoracic tumors into three groups: epidermoids, dermoids and teratomas.

Of the teratoma group only 59 cases have been examined microscopically. A search through the literature does not reveal the type of a teratoma to be discussed in this paper in which the predominant tissue is represented by thymic substance intermingled with cells which closely resemble germinal epithelium and with structures from derivatives of all three germinal layers.

Because of this unusual occurrence together with other interesting morphological and pathological features of this tumor, and because of its importance from the clinical and psychiatric viewpoint the recording of this case seems warranted.

Subsequently the pathology and embryology, in the light of the old and the recent hypotheses, the clinical aspect and the psychiatric viewpoint shall be discussed in the course of this paper.

The Author. *Pathologist, Norwich State Hospital,
Norwich, Connecticut*

SUMMARY

Two reasons for the recording of this case are given: 1. The preponderance of thymic tissue; 2. The presence of germinal cells in this tumor.

On gross inspection the tentative diagnosis "teratoma of the mediastinum" was made. Because of the presence of tissue derivatives from all three germinal layers observed on microscopic examination the diagnosis "teratoma of the mediastinum" was established.

Striking features were large masses of lymphoid tissue including numerous Hassall's bodies, large areas of epithelial cells which closely resembled germ cells, stratified squamous epithelium, clusters of mucous glands, a structure which resembled the macula sacculi of the internal ear, cartilage, bone and solid nests of epithelium, etc.

Old and recent hypotheses are called on to explain the origin and the unusual structures of this tumor. The strongest support for the genesis and the complex structures of this tumor is furnished by the hypothesis of the dislocated tissue, the misplaced blastomere and the migration of germ cells.

The clinical and psychiatric viewpoint is discussed.

Attention is called to the close relationship between persistent thymus, disturbed hormonal sex functions and mental disease on the one hand and tumor formation on the other hand.

Nowhere in the literature has the author come across a growth of this type that was composed of such a great variety of tissue and such extraordinary structures condensed in a very small space as the one reported here.

HISTORY

Very little information is available regarding the history and illness of the patient because he died nine days after his admission.

The patient, a strong healthy white male aged 25, of Latin extraction, was admitted to the Norwich State Hospital on October 24, 1953 on an Emergency Commitment because he suffered from episodes of alternate excitement and depression with incoherence of speech and loss of contact. Diagnosis: Schizophrenic reaction, catatonic type.

No information could be obtained from the patient. The parents claimed that the patient was always quiet, seclusive and bashful and that his illness started about three months prior to his admission when he began to show signs of apathy and withdrawal.

Heredity: Negative.

A few days after his admission the patient developed an elevated temperature which persisted despite daily administration of penicillin. Physical examination failed to reveal any cause for his temperature. Neurological examination, including funduscopic was normal. Chest was clear to percussion and auscultation. Chest x-ray revealed a small patch of pneumonitis in the right lower lobe. Blood serology: negative. The red blood cell count was 4,260,000, and the hemoglobin was 94 per cent. The white blood cell count was 15,000, with a differential count of 87 per cent polymorphonuclear leucocytes and 13 per cent lymphocytes. The blood sugar was 140 mg., urea nitrogen 40.0 mg., and creatinine 1.7 mg. The urine was negative for albumin and sugar. The specific gravity was 1.030. E.K.G.: normal.

In spite of increased penicillin dosage, clyses and alcohol sponges the temperature continued to rise. Intermittent clonic movements of the face and arms were noted. However, the physical examination remained unchanged. The temperature climbed steadily and reached 107° shortly prior to death.

Tentative diagnosis:

1. Pneumonitis, moderate, right lower lobe.
2. Dehydration, moderate.

AUTOPSY REPORT

Autopsy performed by Dr. Pierson on November 2, 1953.

External examination: The body is that of a normally developed, greatly emaciated, moderately jaundiced, young white male of athletic build, weighing approximately 140 pounds, with the body length of 5' 7.5". Pronounced rigor mortis is established throughout; there is considerable post-mortem lividity on the dependent parts of the body. The face is extremely cyanotic. The skin of the upper part of the abdomen, of the chest and of the anterior aspect of the neck shows intense bluish discoloration. Both sternocleidomastoideus muscles are immensely hypertrophied indicating that they were used as auxiliary muscles of respiration. On the lateral aspect of the left thigh there are two scars, one 4" proximal to the knee joint running upward measuring 6 cms. in length and 1 cm. in width, and another one 2" distal to the hip joint running downward measuring 3 cms. in length and 1 cm. in width. The beds of the fingernails are moderately clubbed and extremely cyanotic. There is no

discharge from the eyes, ears, nose and mouth. Most teeth are present and in good condition. Only the lower right first bicuspid and the lower right three molars are missing. Both pupils are round and constricted, measuring 0.3 cm. in diameter each.

Section: The usual Y-shaped incision is made through subcutaneous fat tissue which measures 0.2 cm. in thickness over the thorax and 0.7 cm. in thickness over the abdomen. The muscles of the chest and abdomen are well developed, deep red in color and considerably dehydrated. The dome of the right diaphragm reaches as high as the 4th rib, that of the left diaphragm reaches as high as the 5th rib. Attached to the inner aspect of the manubrium and corpus sterni, there is a flat soft mass of gray color extending from the third costal cartilage to approximately the lower border of the thyroid gland. Adherent to the inner aspect of this mass and intimately connected with it, there is a rounded tumor of moderately firm consistency and deep red color measuring 5.5 cms. x 5 cms. x 3 cms. in its largest dimensions. This tumor overlies immediately the ascending aorta, the aortic arch and the large arteries arising from it exerting considerable pressure on them. It is separated from these structures only by a layer of fascia. The mouths of origin of the great vessels arising from the aortic arch are greatly flattened and narrowed. Both lungs are freely movable in the pleural cavities. The serosal surface of the intestines is smooth, glistening and transparent.

Pericardium: There are approximately 20 cc. of faintly cloudy, light yellow fluid in the pericardial sac.

Heart: Weight 250 Gms., of very flabby consistency. The openings of the tricuspid and bicuspid valves admit each the tips of two fingers. The circumference of the tricuspid, pulmonic, bicuspid and aortic valves measures 14.5 cms., 7.5 cms., 11 cms. and 7 cms., respectively. All the valves are thin and velamentous. Multiple cross sections through the coronary arteries reveal normal vessels. The left ventricle measures 1.2 cms. in thickness and the right ventricle measures 0.2 cm. in thickness. Both ventricles are dilated. The cut surface of the ventricles is pale brown in color. The intimal lining of the ascending aorta is smooth and glistening. The lumen of the aortic arch appears greatly narrowed, measuring 1.5 cms. in diameter (circumference 3.5 cms.).

Right lung: Weight 515 Gms. The surface is smooth, glistening and transparent. The upper and middle lobes are pale pink in color, appear inflated and feel feathery and dry. The crepitation is reduced in both lobes. The cut surface is pale pink in color and dry. The surface of the lower lobe is deep purple and dull. No crepitation can be elicited. The cut surface is grayish-pink showing large, scattered, grayish-yellow patches which feel consolidated. A considerable amount of hemorrhagic practically nonair containing fluid escapes.

Left lung: Weight 410 Gms. The upper lobe is smooth, glistening, transparent, of pale pink color; appears moderately collapsed. The crepitation is somewhat reduced. The cut surface is pale pink and dry. The surface of the lower lobe is purple in color, appears dull and rough. The cut surface is red, showing scattered granular grayish-red areas which feel consolidated. A moderate amount of hemorrhagic, practically nonair containing fluid is scraped away.

Bronchi: Mucous membrane congested. The lumina are filled with hemorrhagic, slightly frothy fluid.

Liver: Weight 2770 Gms. The surface is smooth, glistening, transparent, of purple brown color. The cut surface is brown showing unduly distinct depressed, red, pin-head sized areas separated by brown liver tissue.

Gall bladder: Negative; is thin walled, contains black viscid bile. The extra hepatic bile ducts are patent. On pressure on the gall bladder the bile flows readily into the duodenum.

Spleen: Weight 165 Gms. The surface is of slate color, smooth, glistening and transparent. The cut surface is deep red and of firm consistency showing trabeculae and Malpighian bodies.

Pancreas and intestines: Negative.

Adrenals: Of small size, showing a yellow gray cortex wall demarcated from the medulla.

Stomach: The mucous membrane reveals scattered petechial hemorrhages.

Urinary system: Right kidney—weight 120 Gms. The capsule strips with ease leaving a smooth somewhat pale superficially lobulated surface. The cut surface is pale, the cortex of normal width; the striations are slightly indistinct.

Left kidney—weight 120 Gms. The capsule, surface and cut surface are identical to the right.

Renal pelvis and ureters—Negative.

Sex organs: Prostate—small; the cut surface is white showing glandular tissue.

Testicles—considerably reduced in size, approximately $\frac{2}{3}$ normal size. The cut surface is negative. No cicatrix indicating a tumor regression is seen.

Neck organs: Larynx and thyroid gland—Negative.

Aorta: The intimal lining of the aorta is smooth in its entire course. The lumen of the aorta is narrow throughout. It measures 1.3 cms. in diameter at its bifurcation (3.2 cms. circumference).

Head: The anterior flap of the scalp is densely adherent to the underlying skull and has to be dissected step by step. The cut surface of the calvarium is comparatively thin; otherwise the skull is negative.

Brain: The brain weighs 1050 Gms. after fixation in 10 per cent formalin. The dura mater appears normal. The leptomeninges are thickened and show milky opacity over the convex surface of the hemispheres. The pial vessels are extremely congested. The cerebral cortex appears uniformly narrowed and measures only 0.2 cm. in thickness at the anterior central gyrus. The cortex is of normal color and is well demarcated from the centrum ovale. Multiple frontal sections reveal narrow ventricles, pronounced bilateral shrunken basal ganglia, especially the lentiform nucleus. The markings of the lentiform nucleus are indistinct and the outlines of the fasciculus lenticularis and of the fasciculus thalamomammillaris are quite hazy. The vessels at the base of the brain are thinwalled and elastic. The brain is a fairly firm mass. There are no gross lesions in the cerebellum or in the medulla.

PROVISIONAL ANATOMIC DIAGNOSIS

Persistent thymus; tumor of thymus, undetermined type, probably dermoid cyst or teratoma of the mediastinum;

bilateral bronchopneumonia (lower lobes); edema (right lung; lower lobe); emphysema (right lung, upper and middle lobes); atelectasis (left lung, upper lobe); hypoplasia of testicles; chronic passive congestion of the viscera.

MICROSCOPIC FINDINGS

Heart: Section I and II—The muscle fibers are of normal size. In places the connective tissue septa are infiltrated with fat.

Lung: Section I and II—All alveoli are densely filled with polymorphonuclear leucocytes. In places the alveoli appear distended.

Section III and IV—In certain areas the alveoli and bronchioles are filled with polymorphonuclear leucocytes. In other places the alveoli contain pink staining homogenous material. The capillaries are extremely congested.

Liver: The sinusoids are extremely dilated in places and the liver cell cords appear moderately atrophied.

Spleen: Adrenals, pancreas and prostate—Negative.

Kidney: Section I and II—Negative.

Brain: Preparations from various levels of the cortex which were stained with thionin and toluidine blue show considerably shrunken ganglion cells, pronounced loss of ganglion cells or only shadows of cells. The ganglion cells take only a faint stain. No gliosis or satellitosis is seen.

The shrinkage and the loss of cells is most noticeable in the precentral gyrus which shows grossly the greatest atrophy of the cortex.

Sections from the lentiform nucleus reveal likewise a great loss of ganglion cells.

Preparations stained with Loyez show extreme shrinkage of the striate body with loss of markings, especially loss of the outline of the external and internal medullary lamina and haziness of the fasciculus lenticularis and the fasciculus thalamomammillaris.

Persistent thymus: Shows lobules composed of lymphoid tissue with interspersed Hassall's bodies. The lobules are separated by connective tissue septa. The lymphoid cells are closely packed. There is no differentiation into cortex and medulla. No reticular cells are discernible. There are numerous arteries and large blood spaces and only a very scanty amount of fat. Striking is the great number of Hassall's bodies and their varied appearance as to size and morphology. They are quite identical as to their special peculiarities to those that will be described under microscopic examination of the teratoma. For this reason we refer to their histological description under teratoma section 2a in order to avoid repetition.

Diagnosis: Persistent thymus, moderate fatty infiltration of the myocardium, bilateral bronchopneumonia, edema and emphysema of the lungs, chronic passive congestion of the viscera.

The persistent thymus and the thymic component of the teratoma, as will be seen later, present many identical features. They have in common the same closely packed lymphocytes, the arteries and large blood spaces, the small amount of adipose tissue and particularly the very same variety of Hassall's bodies remarkable for their diversity as to size and structure. The thymic component of the teratoma differs only by the presence of germinal-like cells

to which will be referred later under the description of the teratoma. The origin of the Hassall's bodies will be discussed under the development of the thymus.

The detailed macroscopic and microscopic description of the tumor will be related hereafter.

Macroscopic examination of the tumor: The specimen consists of an ovoid shaped tumor (Figure 1) weighing 50 Gms. after fixation in 10 per cent formalin and measuring 5.5 cms. x 5 cms. x 3.5 cms. in its largest dimensions.

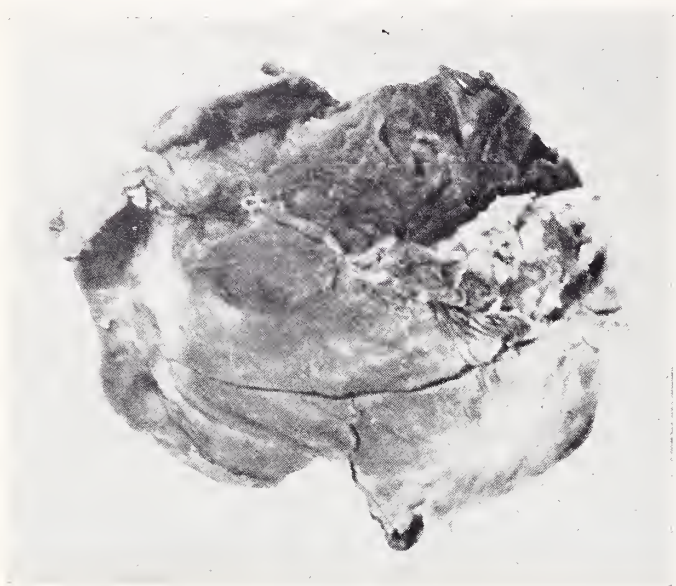


FIGURE 1

Mediastinal teratoma, natural size

The tumor is enveloped with a connective tissue capsule which is partly grayish-white, smooth, glistening, transparent and partly deep red and rough and covered by fibrous bands.

On palpation the tumor reveals different degrees of firmness disclosing tissues of very soft, cystic, compact, solid and even hard and fragile consistency.

On section (Figure 2) the tumor presents a framework of gray connective tissue in which there is embedded haphazardly a great variety of tissue remarkable for its great difference in color and firmness. The stroma is riddled by cysts and blood spaces, varying in size from a few millimeters to approximately 1 cm. in diameter.

The majority of the cysts are empty but some are filled with soft material of grayish-green color. The cysts are lined by different types of epithelium the appearance of which is too manifold to be differentiated except under the microscope.

A striking feature is the mosaic-like pattern of the cut surface in which there are implanted areas of gray-blue cartilage side by side with deep red blood spaces, yellow patches suggesting fat tissue, sponglike appearing areas composed of glandular or cystic structures, islands of tissue which are hard and fragile to the touch suggesting bone lamellae, small white firm patches resembling solid epithelial structures as seen in carcinomatous growths and other varieties of tissue the nature of which cannot be identified with the naked eye.

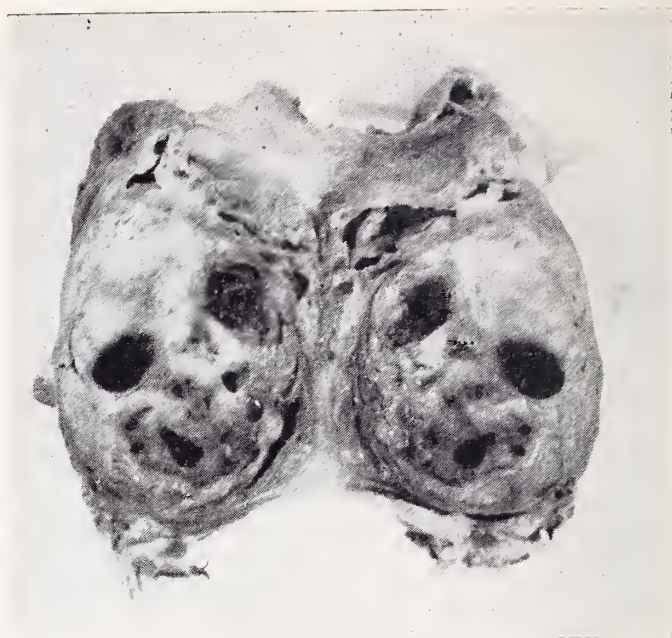


FIGURE 2

Cut surface of the teratoma showing the mosaic-like pattern with cysts of variable size, large blood spaces, cartilage, etc., embedded in a connective tissue framework; natural size

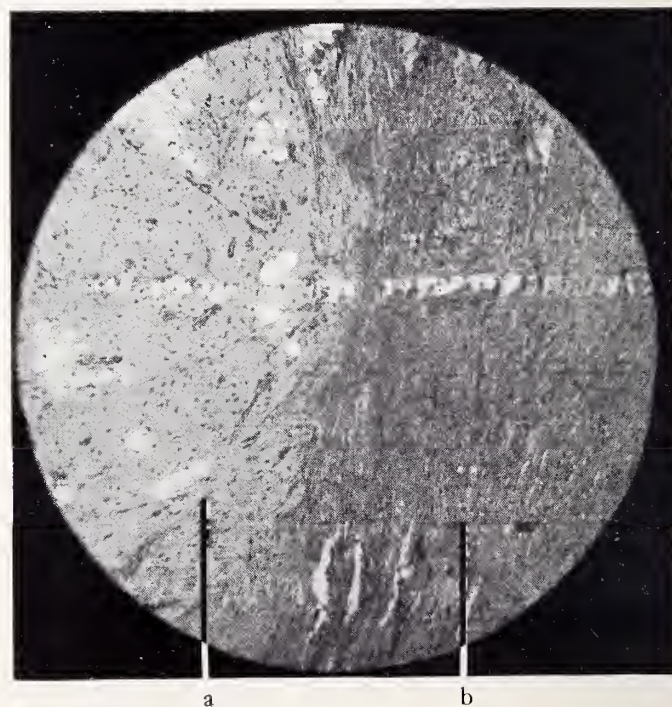


FIGURE 3

Various forms of connective tissue

- a. Branching stellate cells in a scanty loosely arranged intercellular substance
- b. Adult type of mature connective tissue with fibroglia and dense collagen fibers; $\times 100$

Macroscopic impression: Teratoma.

Microscopic examination of the tumor: For microscopic examination pieces from various parts of the tumor were selected. The microscopic picture offers an even greater perplexing variety of tissues as observed on gross examination. Practically every preparation presents a different appearance from any other. Each section reveals either a few variants of tissue derived from at least two germ layers, or even a group of structures originating from all three germ layers. The combined microscopic findings from only two or three different sections of the tumor complete the components of a teratoma which is defined as a growth showing the distinctive feature of the presence of derivatives from all three germinal layers.

It would seem desirable to list the various tissues in the order of the derivatives from the various germ layers but the morphologic appearance and the great variety of tissue of each single preparation does not make such a description advisable. Therefore the various sections removed from the tumor shall be described regardless of their embryonic origin.

Section 1. The striking feature of this preparation is the multitude of different types of tissue lying side by side in a comparatively very small area of the tumor apparently irrespective of purposeful function or orderly arrangement.

These structures are embedded in connective tissue which likewise lacks all uniformity as to morphological structure and staining properties alternating in appearance according to the stage and phase of its development (Figure 3). It exhibits transitions from the youngest embryonal elements consisting of a network of branching stellate or fusiform cells with scanty, very loosely arranged, intercellular substance to the adult type of the mature connective tissue cell with fibroglia and dense collagen fibers.

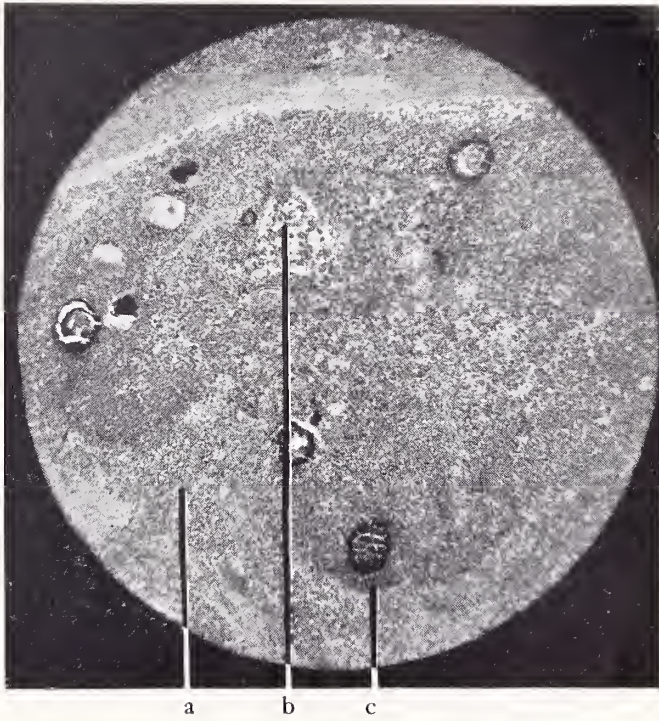


FIGURE 5 $\times 100$

- Different areas showing two types of cells
- a. Large masses of lymphoid tissue intermingled
 - b. With epithelial cells, which are interpreted as primordial germ cells
 - c. Numerous calcified Hassall's bodies

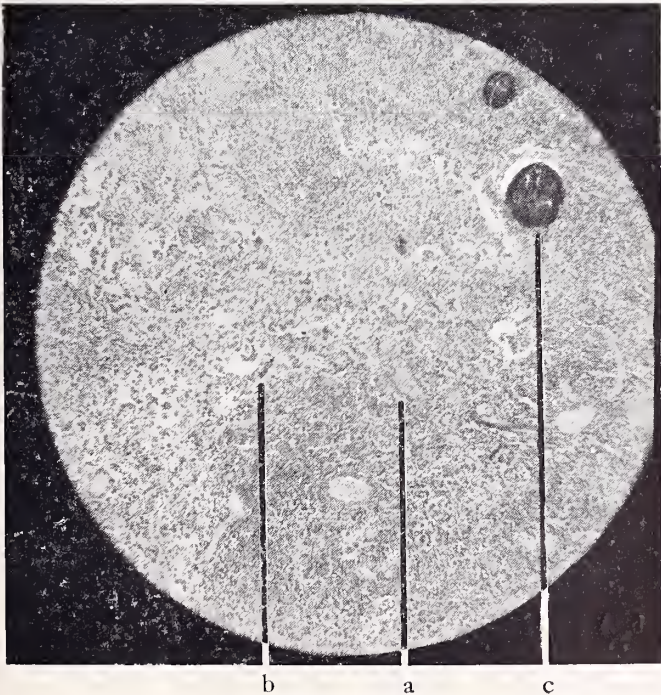


FIGURE 4 $\times 100$

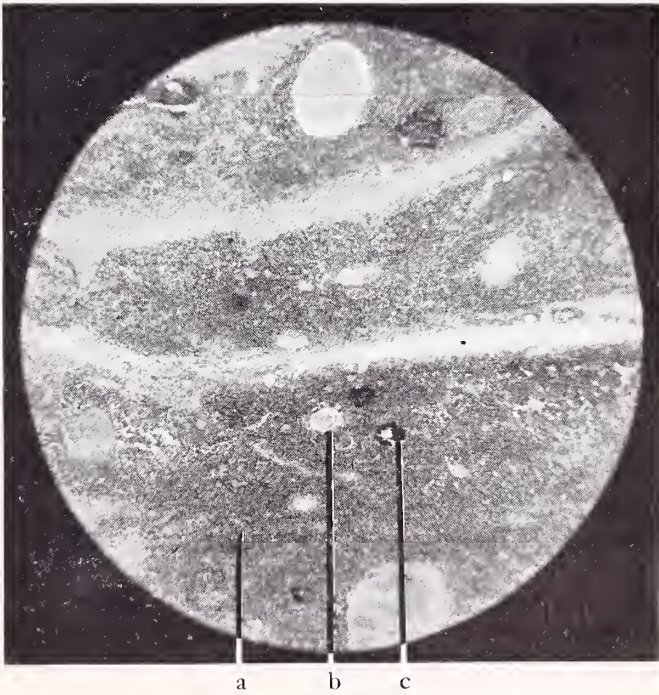


FIGURE 6 $\times 32$

The following structures are found in this polymorphic stroma.

a. Large masses of irregularly distributed lymphoid structures (Figure 4) enclosing rounded calcified Hassall's bodies (Figure 4). This tissue is identical to the histological structure of the patient's persistent thymus of the mature type with the exception that the lymphoid tissue present in the tumor is intermingled with epithelial cells (Figures 4, 5 and 8) which so closely resemble primitive germ cells that they may be accepted as such. These epithelial cells are large and round, displaying a relatively large deep staining round nucleus with a sharply defined membrane and rich granular network of chromatin. The cytoplasm stains rather feebly. (Figure 8.) These cells are either diffusely distributed amongst the lymphoid tissue or lie in groups or show distinct alveolar arrangement (Figures 4 and 5). This cell type has a strikingly close resemblance to the cells of the seminoma. (Figure 8.)

b. Sheets of detached stratified squamous epithelium lying casually in an empty space surrounded by connective tissue or by a cluster of mucous glands with basal nuclei as seen in the respiratory tract (Figure 18).

c. Groups of large cysts varying in size and shape. Some of these cysts are lined by only one type of epithelium (stratified high columnar epithelium) exhibiting papilliform ingrowths (Figure 9), others show a sudden change from stratified columnar to stratified squamous epithelium. (Figure 9.)

This is a sign that they have formed, not from one or other germinal layer but from cells belonging to a period further back in ontogeny and capable of giving rise to tissue representing two germinal layers.⁴²

d. A large elongated cyst and narrow spaces lined by only one layer of high columnar epithelium with basally located nuclei.

e. Scattered clusters of glands filled with pink staining material.

f. Groups of acini which are lined by cuboidal epithelium containing homogeneous pink staining material showing great likeness to thyroid tissue.

g. Scattered areas of fat tissue.

h. Wide mono- and multilocular blood spaces occupying large areas often forming a structure resembling a cavernous angioma.

i. A structure which is composed of several layers of young squamous epithelium surmounted by tall columnar elements resting on a basement membrane. The tall columnar cells remind one of the sustentacular cells of the macula sacculi containing oval nuclei and show at their edges a gradual transition into the simple squamous epithelium characteristic of the remainder of the membranous labyrinth. (Figure 17.)

Section 2. This section is another example of the multitude of different structures condensed in a small area. The tissue is likewise embedded in the same polymorphic, embryonic connective tissue, but the components of the tissue differ from the above section.

a. The bulk of the section is composed of thymus intermingled with the mentioned primitive germ cells.



FIGURE 7 $\times 100$ enlargement of Figure 6
Lymphoid cells with Hassall's bodies in different stages of development

- a. Spherical or oval Hassall's bodies showing concentrically arranged peripheral layers enclosing a hyalinized central part
- b. Concentrically arranged flattened cells surrounding a hyalinized central part
- c. Calcified Hassall's bodies
- d. Lymphoid cells

A conspicuous feature in this thymic tissue is the great number of Hassall's bodies. They reveal the same varied appearance as to size and morphology as seen in the persistent thymus. They are either spherical bodies which are composed of concentrically arranged flattened cells or they show only at the periphery concentrically arranged cells, while the center appears hyalinized. Others show partial or complete hyalinization. A great number are perfectly necrotic, take a pink stain with eosin and are remarkable for their variety as to size and structure. Some appear to be fused concentric bodies with still discernable rounded outlines of each, others seem to be broken down into irregularly outlined detached necrotic particles. All these structures lie in spaces that are lined by endothelial cells or they are in close contact with a layer of surrounding endothelium. (Figures 5, 6 and 7.)

The origin of the Hassall's bodies in relation to their microscopic appearance in the persistent thymus as well as in the teratoma will be discussed under the "development of the thymus."

b. A new type of tissue are large bone lamellae embedded in this embryonic connective tissue. (Figure 10.) The bone structure shows irregularly calcified bone in the center surrounded by noncalcified osteoid tissue. The latter exhibits at the periphery a distinct row of osteoblasts. The bone

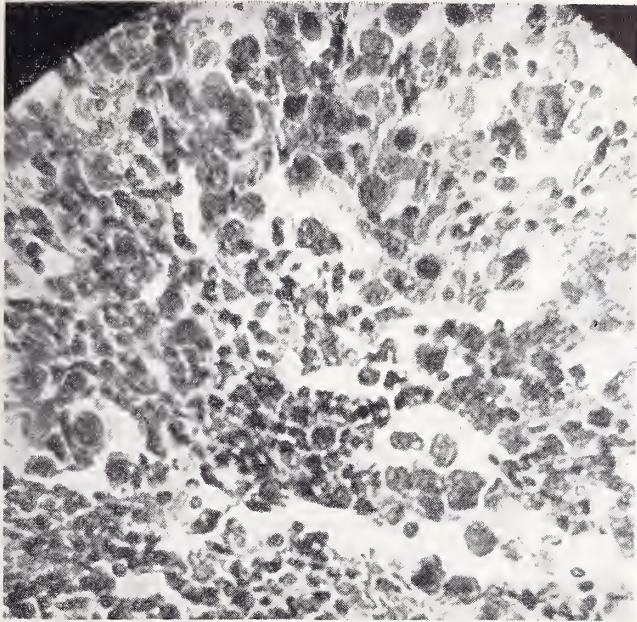


FIGURE 8

Enlargement of germinal cells of Figure 5 showing large round cells displaying a large deep staining nucleus with a rich granular network of chromatin resembling the cells of seminoma; $\times 440$

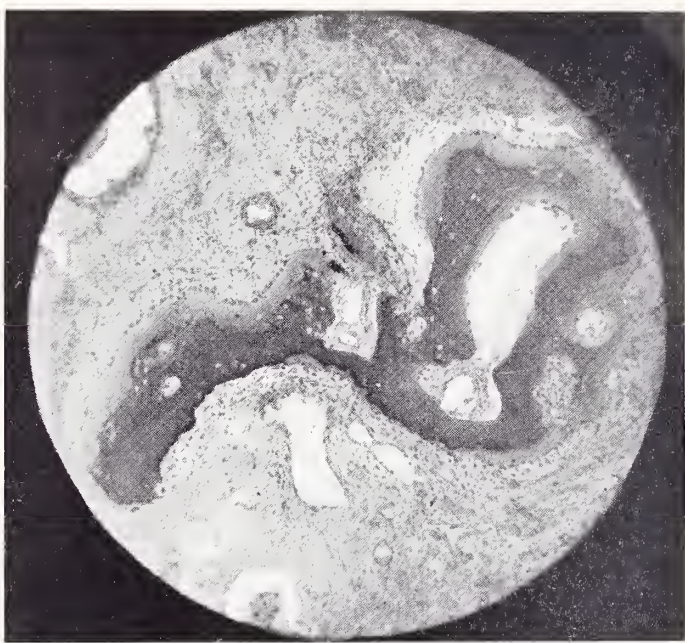


FIGURE 10

A bone lamella surrounded by osteoid tissue. At the extreme outer and inner margin a distinct row of osteoblasts; $\times 100$

lamellae enclose loose connective tissue of the embryonic type. The latter is separated from the osteoid tissue by another inner row of osteoblasts.

c. The most striking structure is a large adenomatous growth consisting of closely packed glands and cysts of variable size lined by different types of epithelium (Figure 11). While some glands and cysts show low cuboidal

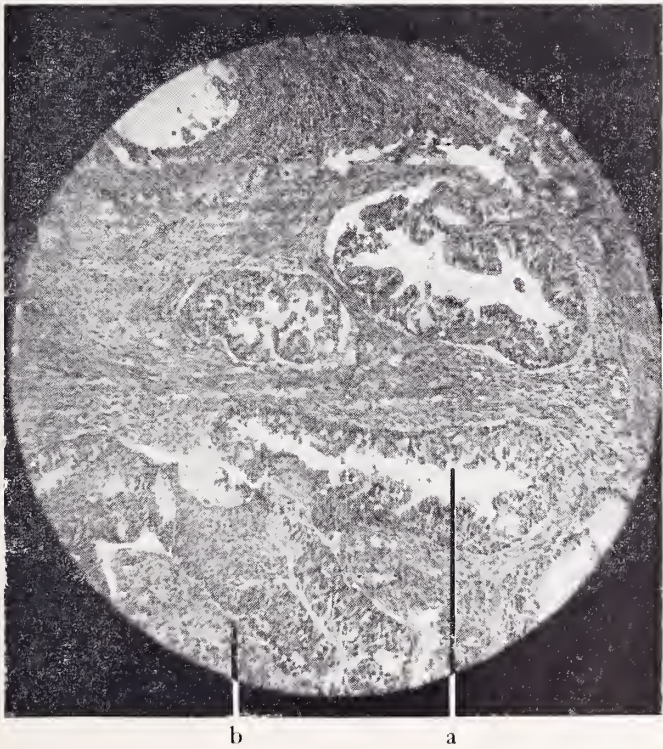


FIGURE 9

a. Large cysts lined by stratified high columnar epithelium passing over suddenly into
b. Squamous epithelium in various places; $\times 100$

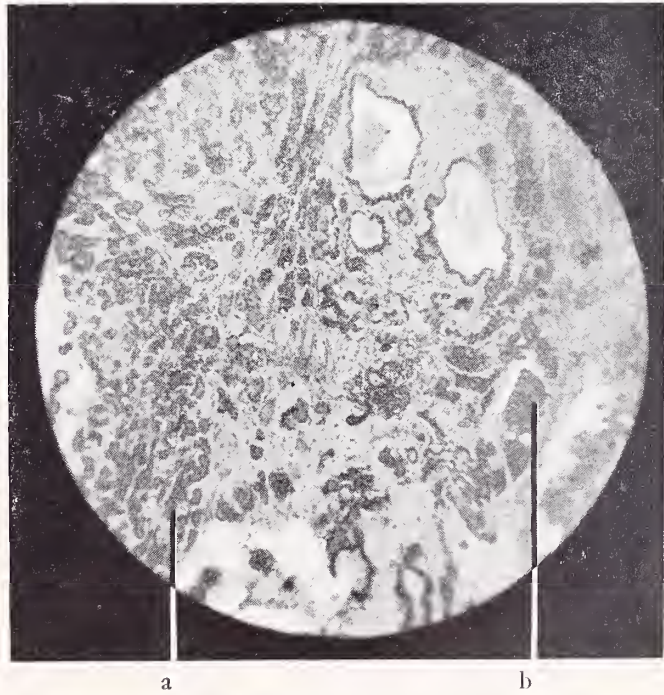
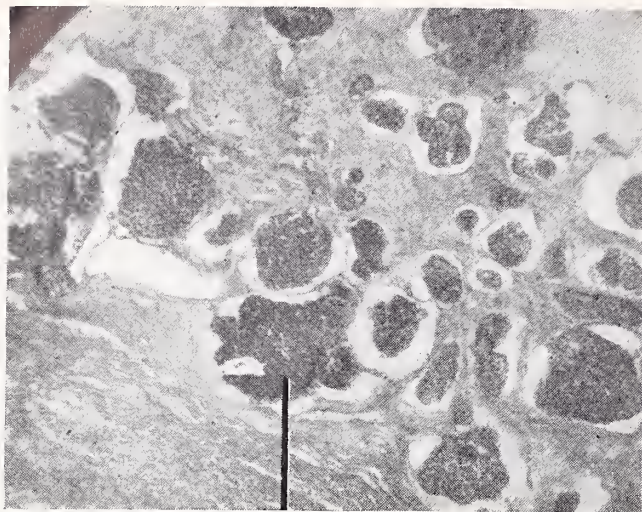


FIGURE 11 $\times 100$

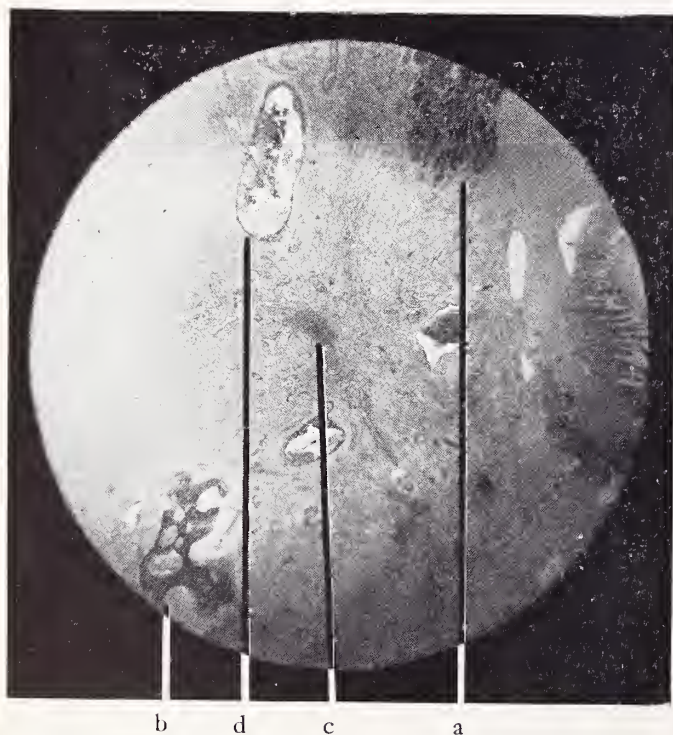


b

FIGURE 12 $\times 100$

a. A large adenomatous structure composed of cysts and closely arranged glands passing over abruptly into

b. A carcinomatous pattern made up of solid nests of indifferent epithelium



b

d

c

a

FIGURE 13

Derivates of two different germ layers lying closing together

a. An adenomatous structure (top)

b. A bone lamella with peripheral osteoid tissue surrounded by osteoblasts (bottom)

c. Lymphoid tissue

d. Blood vessels and large blood spaces; $\times 32$

epithelium, others are lined by high columnar epithelium, or by pale high columnar epithelium with basal nuclei as seen in the mucous glands of the trachea and bronchi (Figure 18). This complex of glandular and cystic arrangement is suddenly found to cease to give way to a large area composed of solid nests of indifferent epithelium (Figures 11 and 12).

Section 3. This section shows similar structures as described in the previous preparations such as widespread adenomatous growths, large cysts of variable size, bone lamellae surrounded by osteoblasts (Figures 13, 14 and 15), large blood spaces, fat tissue, predominant thymic tissue with Hassall's bodies and interspersed groups of those large cells with dark staining nuclei which resemble germinal epithelium. In addition there are large plates of hyaline cartilage which include islands of embryonic connective tissue (Figure 16). The cartilage is composed of a homogeneous intercellular matrix and the cartilage cells which are situated in smooth walled lacunae varying greatly in size and shape. The lacunae contain one or two up to seven nuclei embedded in one mass of vacuolated cytoplasm indicating rapid cell division. The various components of the cartilage disclose a rather varified picture. Frequently the cartilage cells are irregularly distributed and of variable size, shape and position. Some are widely spaced and large with a great deal of intercellular substance displaying round or irregularly outlined nuclei of variable size, number, position and chromatin content. In other places the cells are quite small, lie close together, are triangular or spindle shaped. This polymorphic structure of the cartilage seems to indicate various stages of development. The islands of cartilage appear to be quite detached and are separated from the adenomatous growths by perichondrium made up of young connective tissue (Figure 16). Besides the cartilage this preparation shows in addition groups and nests of large deeply pigmented cells which contain a round nucleus. In places these cells assume an alveolar arrangement or they are lining large blood spaces in a single row, or they are heaped up to form several rows. These cells are so undifferentiated as to be difficult of recognition.

Section 4. This shows cartilage of a more atypical structure than the type described in the previous section in so far as the cartilage cells reveal an even greater variety as to size, shape, intercellular substance and arrangement. This cartilage passes over without any transition or intervening tissue into a large area composed of solid nests of indifferent epithelium (Figure 19).

The remainder of the preparations shows more or less a repetition of the preceding sections.

The presence of tissue from the derivatives of all germ layers leaves no doubt as to the diagnosis of this tumor.

The ectoderm is represented by squamous epithelium. The various glands and cysts, lined by cubical or columnar epithelium are derivatives of the entoderm, while the lymphoid tissue, the cartilage, bone, the connective tissue, the smooth muscle, adipose tissue, blood vessels and blood spaces stand for the mesoderm.

These various tissues are partly mature, partly immature. The immature character is particularly conspicuous by the presence of the young squamous epithelium, the embryonic type of connective tissue, the sudden change of squamous epithelium to stratified columnar epithelium, and most

strikingly by the occurrence of areas showing a malignant manifestation, a definite sign of immaturity. All these tissues are combined in bewildering variation without any apparent tendency of correlation.

Diagnosis: Teratoma of the thymus.

DISCUSSION

Before attempting to discuss the genesis of this teratoma it seems appropriate to quote the present viewpoints on the development of the thymus which may throw some light on certain unusual features of this tumor and help to explain its morphogenesis.

The thymus appears in the form of two flask-shaped entodermal diverticula which arise, one on either side from the third branchial pouch and extend lateralward and backward into the surrounding mesoderm in front of the ventral aortae. Here they meet and become joined to one another by connective tissue, but there is never any fusion of the thymus tissue proper.⁴

The third branchial cleft, an ectodermal derivative, opens onto the surface of the skin through the cervical sinus and becomes dilated at its distal end to form the cervical vesicle. Subsequently the latter severs its cutaneous connection, but remains in close contact with the third pharyngeal pouch. Thereafter, according to Weller,⁵ the cervical vesicle slowly degenerates and disappears. Norris,⁶ however, found that the cervical vesicle spreads over the

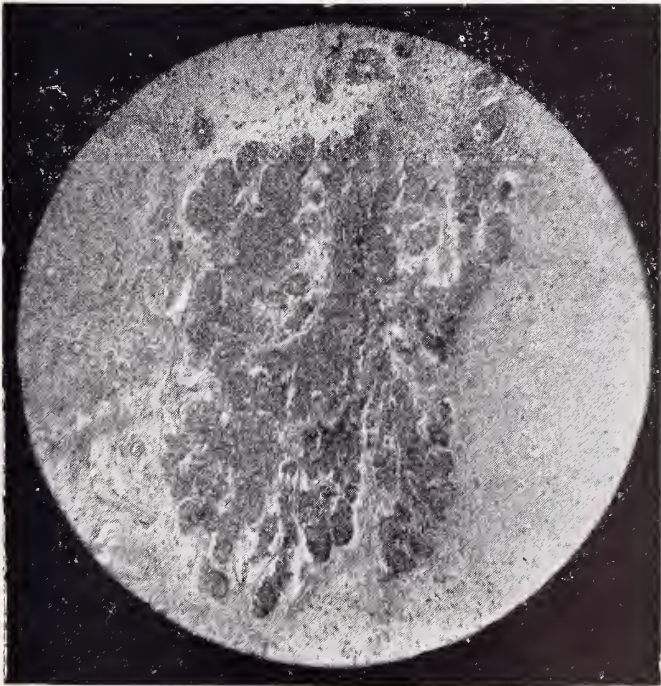


FIGURE 14
Enlargement of the adenomatous structure of Figure 13; $\times 100$



FIGURE 15
Enlargement of the bone lamella of Figure 13
 $\times 100$

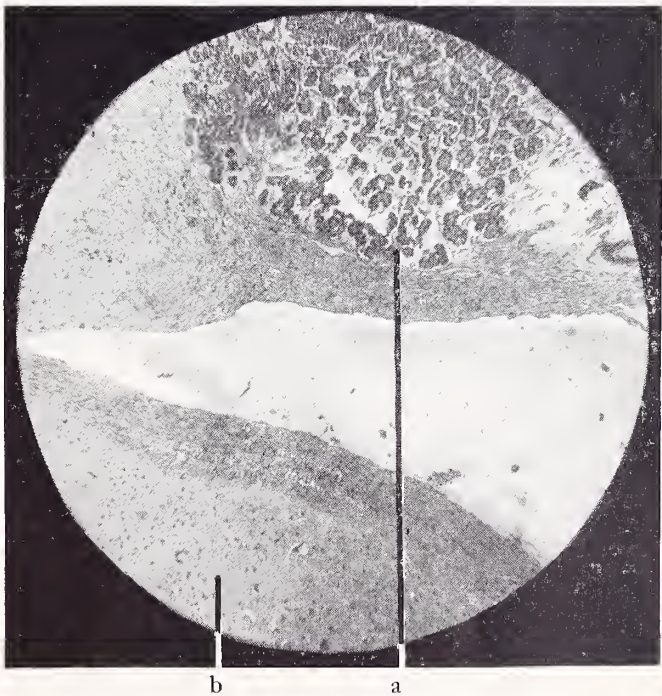


FIGURE 16
Derivatives of other structures of different germ layers
a. An adenomatous structure (top)
b. Cartilage surrounded by perichondrium separated by a cyst; $\times 32$

surface of the entodermal thymus, forming an ectodermal layer.

By further proliferation of the cells lining the flask, buds of cells are formed which become surrounded and isolated by the invading mesoderm. In the latter, numerous lymphocytes make their appearance, and are aggregated to form lymphoid follicles. These lymphoid cells are probably derivatives of the entodermal cells which lined the original diverticula and their subdivisions.⁴

Some of the ectodermal cells become disengaged and are displaced into the medulla by swarms of lymphocytes that are crowding into the cortex. The isolated ectodermal cells are at first recognizable by their large size and vesicular nuclei; subsequently they form Hassall's corpuscles.⁶

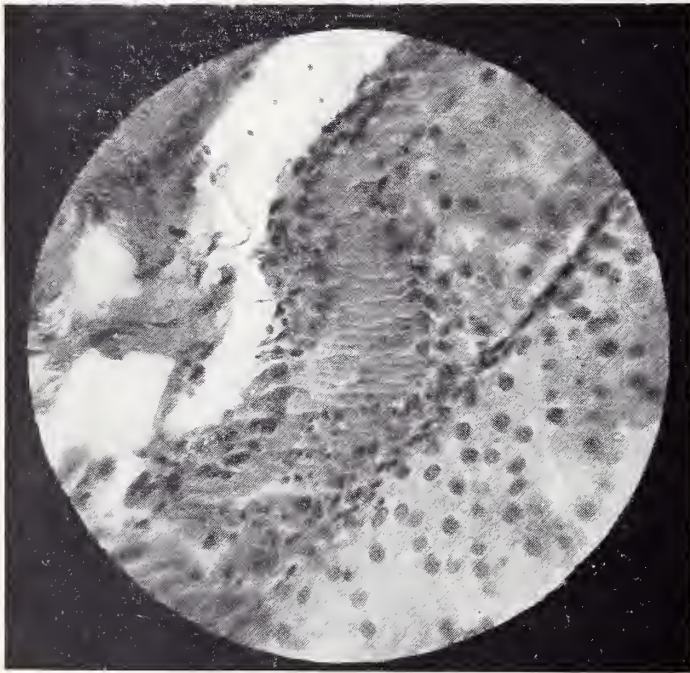


FIGURE 17

A structure reminding of the sustentacular cells of the macula sacculi. Tall columnar cells passing over into simple squamous epithelium characteristic of the remainder of the membranous labyrinth; $\times 440$

According to Keith,⁷ the Hassall's bodies arise during the degeneration of capillary vessels within the thymus. The endothelial cells lining segments of the degenerating capillaries may proliferate, occlude the lumen, and thus give rise to a Hassall's corpuscle.

In connection with this statement it should be mentioned that the majority of the Hassall's bodies in the persistent thymus and in the tumor of this case, whether composed of concentrically arranged

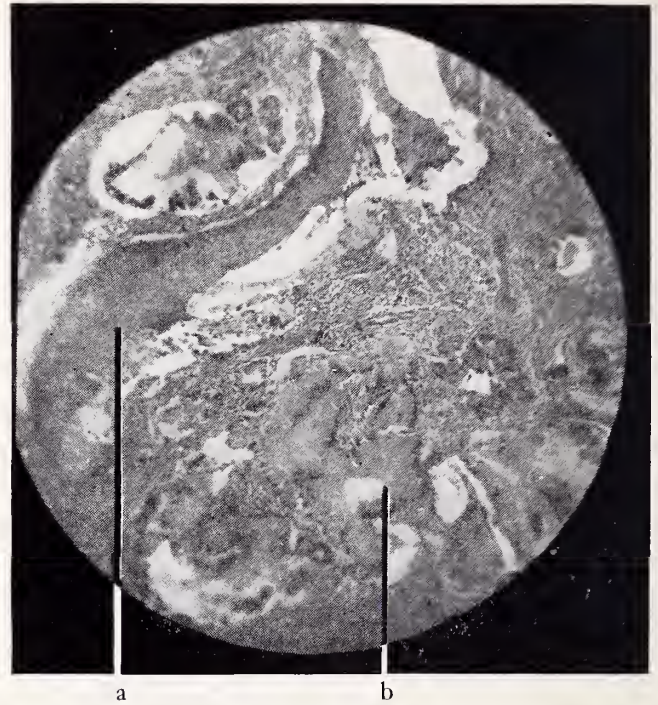


FIGURE 18

- a. Sheets of detached stratified squamous epithelium
- b. Clusters of mucous glands as seen in the respiratory tract; $\times 100$

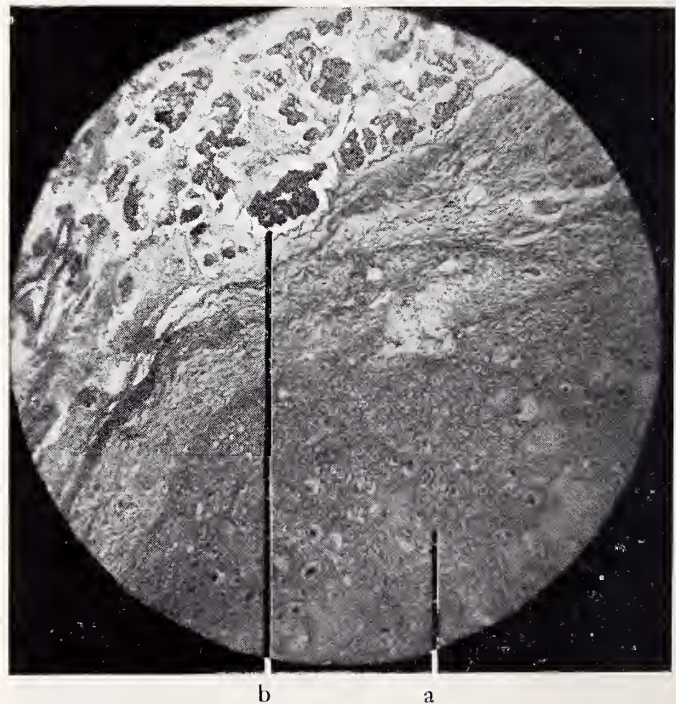


FIGURE 19

- a. Atypical areas of cartilage (bottom) passing over into
- b. Solid nests made up of indifferent epithelium (top); $\times 100$

cells, necrotic tissue, or of partly or completely calcified rounded structures, are surrounded by a wall of smooth muscle lined by endothelial cells or only by a layer of endothelial cells. These structures surrounding the Hassall's bodies in the persistent thymus as well as within the tumor so closely resemble arterioles or capillaries that it seems justified to interpret them as such and support the hypothesis of the origin of Hassall's bodies from degenerated capillary endothelial proliferation.

The genesis of teratoma is still far from understood. With the development of embryology during the first half of the nineteenth century,⁸ cases of teratoma were classified into two main groups: 1. ovarian and testicular teratoma which were believed to arise spontaneously from germ cells by a process of parthenogenesis; 2. the other group of teratoma which was regarded as an included twin, as a "fetus in fetu."

Both hypotheses are still widely accepted. However, more recent investigations dispute these theories. In a series of papers Nicholson⁹ and Willis¹⁰ prove by conclusive reasons that a fetus is not a teratoma and the hypothesis of fetus in fetu is disposed of. Also the so-called parthenogenic development of the germ cells in the gonads seems to lack scientific evidence. Experimental parthenogenesis invariably produces a recognizable embryo; not a tumor.¹¹ A teratoma is a true tumor and should be distinguished from non-neoplastic malformations of all kinds, whether relatively simple heteropias of particular tissues or complex malformations such as double monsters or imperfect twins.¹²

During the greater part of the nineteenth century teratoma of the mediastinum in particular were considered to result from a faulty development of the branchial cleft or they were interpreted as an included twin. Most cases of teratoma reported at this time were tumors of the cystic variety composed almost only of skin and its appendages. Pinders,¹³ Pflanz,¹⁴ Virchow¹ and Wilms¹⁵ considered teratoma of this type to be derived from the branchial cleft.

The opinion that mediastinal tumors probably result from embryologic maldevelopment within the branchial cleft in the vicinity of the thymus anlage and the great vessels with which they descend into the chest is shared by more recent investigators.⁴³

The discussion of the genesis of our thymic teratoma is a particularly problematic task for two reasons.

1. Because of the preponderance of thymus tissue.
2. Because of the presence of cells which so closely resemble germinal cells that practically without any doubt they may be accepted as such.

The presence of thymus has been reported by a number of investigators. Hoernecke¹⁸ mentions in a case report of teratoma of the anterior mediastinum amongst connective tissue, epidermis, epithelium resembling fetal mucous membrane of the mouth, a small complex of thymic tissue composed of only the cortical layer with some Hassall's bodies. The latter showed concentric arrangement without the presence of cells except at the periphery. No medulla could be found. It was a mature thymus in accordance with the age of the bearer.

The presence of thymus in teratoma made certain investigators believe that the thymus is the origin of mediastinal teratomas. Especially Marchand¹⁹ was an emphatic supporter of this hypothesis. He found the thymus gland intimately associated with teratoma of the mediastinum in the case studied by him and therefore thought the origin of the growth to be in the thymus, suggesting a possible derivation from the corpuscles of Hassall. Rolleston²⁰ described a tumor of the anterior mediastinum which he believes to be thymic in origin, since the tumor was anatomically in the situation of the remains of the thymus gland and because of the presence of small round cells seen normally in a young thymus. Cordes¹⁷ and Renen²¹ also mention mediastinal tumors as of thymic origin and Pinders¹³ describes thymus-like tissue in a case of a dermoid cyst of the anterior mediastinum without the presence of the characteristic Hassall's bodies.

Harrington²² reported that he found thymic tissue in one case out of eleven mediastinal and intrathoracic tumors.

Also Schlumberger²³ in a more recent very elaborate paper on teratomas of the anterior mediastinum concludes that teratoma of the anterior mediastinum probably arises from tissue dislocation in the anlage of the thymus. In 16 cases reported by him thymic tissue was found within the capsule in four instances. He feels that of all the branchiogenic structures the thymus "anlage" is the most plausible site for the development of mediastinal tumors. The thymus is the only branchiogenic organ that regularly descends into the anterior mediastinum. During the embryogenesis of the thymus there is intimate association of ectoderm and entoderm, accompanied by mesenchyme.

With these considerations in mind we may explain the thymic origin of this tumor, which was in close connection with the persistent thymus.

The evidence in favor of a thymic origin of our tumor seems particularly strong. The above quoted authors support the thymic origin on the ground of only small complexes of thymus or only thymus-like tissue with or without the characteristic Hassall's bodies, while in our tumor the great preponderance of all the structures present is made up by thymus tissue with unusual numerous Hassall's bodies.

The great number of calcified Hassall's bodies in this persistent thymus as well as in our tumor is a striking phenomenon. They are present in the stage of all transitions from rounded, partly or completely necrotic bodies to those showing partial or complete calcification. Sometimes several necrotic bodies are fused to form more or less larger necrotic masses. These necrotic Hassall's bodies may well have acted according to the hypothesis of tissue dislocation with liberation of organizers as a stimulant to induce the formation of the teratoma in a possible detached piece of thymus during embryonic life.

Since the beginning of the 20th century great progress has been made in the investigation of the function of the intracellular substance which acts as the organizer. Spemann²⁴ demonstrated that crushing of the cells had no harmful effect on their inductive activity. Later several investigators found that boiling the cells likewise did not affect their ability to act as organizers. Holtfreter²⁵ demonstrated that after boiling parts of the gastrula with formerly no ability for induction, now had acquired it.

"Experimental embryology has demonstrated the capacity of tissues to differentiate in directions other than normally expressed during embryogenesis. Not only is a dislocated tissue subjected to the action of the organizers of its new environment, but its capacity to react to them may be altered. As a result, it may differentiate into structures that are wholly foreign to that region."²⁶

These discoveries explain as quite natural the strange components, particularly the presence of germ cells intermingled diffusely with other structures in this thymic tumor. Further support for the explanation of the development of structures so foreign to this region we may obtain from: 1. the hypothesis of a misplaced blastomere, and 2. from the hypothesis of the extragonadal germ cells. The former hypothesis was called on for the past fifty

years to account for the presence of teratoma in various parts of the body.

It is known that the fertilized ovum is totipotent; that is, it is capable of giving rise to all the tissues of the body. So too are the first segmentation spheres as is proven by the development of twins from a single ovum. In later stages of segmentation the blastomeres remain multipotent or capable of producing several tissues. Still later, the destiny of the cells becomes more rigidly prescribed and they are limited to the formation of certain tissues. When the germ layers are defined, elements from each of these layers have the power of producing ectoderm, entoderm or mesoderm structures only and are even more closely confined according to their point of origin in the layer. If the isolated blastomere should remain stagnant during the growth of the host it might be expected to produce by later growth a teratoma composed of embryonic tissue.²⁷

Since Waldeyer in 1870 discovered that the primordial germ cells do not arise in the gonads, great progress has been made in the tracing of the path of germ cell migration. In 1914 Swift²⁸ demonstrated that the primordial germ cells of the chick embryo arise in a crescent-shaped region of germ wall entoderm at the anterior margin of the area pellucida. At first these cells are in the space between entoderm and ectoderm; with the appearance of the mesoderm they enter this layer and the developing blood vessels within it. Early in their course they migrate by ameboid movement, but subsequently they are carried in the blood stream to all parts of the embryo. Later the primordial germ cells become more numerous in the vessels of the splanchnic mesoderm. They continue to accumulate in the radix mesenterii and the celomic epithelium on both sides of the celomic angle; elsewhere they degenerate and disappear. Those in the celomic epithelium remain there until the formation of the gonad begins, when they gradually pass into that organ. This concept of a germ pathway or Keimbahn has been supported by numerous investigations, among them those of Reagan,²⁹ and more recently of Dantschakoff, Dantschakoff, Jr. and Bereskina.³⁰

It seems quite problematic that the germ cells should be held responsible for the formation of the teratoma, but the theory of extragonadal germ cells throws light on the presence of germ cells in this tumor and it is quite likely that they were arrested during their migration in this region for some unknown reason, possibly due to similar disturbance

in the process of development as that which caused the growth of the teratoma.

The presence of germ cells in a thymic mediastinal tumor is extremely rare. A search through the literature disclosed only one single case recently reported by Pugsley and Carlton.³¹ These authors published two cases of mediastinal primary teratoid tumors of the thymus. In one of the tumors a nodule of germinalomatous tissue was found. A metastatic growth from a primary tumor in the testicles was ruled out. Multiple block sections of the entire testicular parenchyma revealed no growth. No cicatrix indicating regression of the tumor was found. The authors cannot offer a satisfactory explanation for the localization of primordial germ cells in the thymic anlage.

The above description and discussions may illustrate the significance of these tumors from the pathological viewpoint because of their wealth of speculative possibilities and their close relationship between abnormal conditions and early embryonic development.

In no lesser degree the presence of mediastinal tumors is of great importance clinically because all tumors of the mediastinum are potentially fatal. Many mediastinal tumors are symptomless and those which produce symptoms are usually of extreme size, degenerated or perforated. The clinical symptoms are extremely nonspecific and are common to almost all intrathoracic diseases from the common cold to cancer of the lungs. At times patients with intrathoracic tumors, especially mediastinal tumors, have pressure symptoms such as hoarseness, dysphagia, phrenic nerve paralysis, Horner's syndrome, obstruction of the superior vena cava.³²

Also Hoerneck¹⁸ mentions the high mortality of mediastinal tumors which is not limited to those revealing malignant degeneration. Even relatively small and slowly growing tumors because of their localization are not compatible with life, and because of the harmful mechanical effect on the organs of respiration and circulation. It is known from the histories that the unfortunate sufferers from teratoma either die a painful death from the most severe symptoms of asphyxia or venous congestion. Even those who are operated on most often succumb. Metastases are clinically of little importance because death supervenes prior to their development.¹⁸

In recent years the outlook in regard to treatment of this type of tumors is more hopeful and the

development of thoracic surgery has led to successful surgical treatments in many cases.

Harrington²² advises that all teratoid tumors should be removed surgically, regardless of whether the growth is producing symptoms. If these tumors are allowed to remain there is danger that the growth will undergo malignant change. If the growth remains benign the course is usually progressive and will ultimately cause serious complications and chronic invalidism, either from pressure on the surrounding vital organs, particularly the heart and lung, or from the production of inflammatory changes. Not uncommonly infection develops and the growths rupture into the lung from pressure and are secondarily infected, producing bronchial fistula or secondary abscess which often produces severe hemorrhage from the lungs, and may result fatally.

The results of surgical treatment in the cases reported in the literature are summarized by Laipply³³ the following way. Of the 126 patients subjected to surgical treatment, 65 (or 51.5 per cent) were cured, 33 (or 26.2 per cent) were improved and 23 (or 18.3 per cent) died. Complete extirpation of the tumor cured 55 (or 72.4 per cent), or 76 patients so treated. Thus, the treatment of choice is radical excision. This is best accomplished before pressure symptoms or infection have supervened. Boyd³² suggests more chest surveys on a massive scale and operation as soon as possible in order to save more lives in patients with intrathoracic lesions.

The tumor in our patient did not attain a very large size, it was overlooked apparently, because it did not cause any clinical symptoms and was detected as an incidental, unexpected observation at autopsy. However, the necropsy findings showed evidence of asphyxia symptoms due to pressure on the great arteries arising from the aortic arch and on the vena cava superior. This pressure from the tumor must have persisted for a certain length of time and must have been at least a contributory cause of death. At autopsy the face revealed a considerable degree of cyanosis, there was extreme chronic passive congestion of the viscera and immense hypertrophy of the sternomastoid muscles indicating that they were used as auxiliary muscles of respiration.

Since the beginning of this century cases of primary tumors of the thymus glands coming to operation or autopsy have been reported to be associated with myasthenia gravis in almost 100 per cent of cases. These tumors lie in the thymic region and are

attached to the pericardium. They may be either encapsulated or solid.³⁴

Adalberto R. Goni³⁵ is not so positive with his statements. He says: "The arguments for what may be called the thymogenic theory of myasthenia gravis are still in full discussion. Certain facts give strong support, but it is too bold to affirm that the unknown cause of this malady has been discovered. In reviewing the physiopathogenesis of the myasthenic contraction we believe that the thymus is either an epiphenomenon or a coadjuvant factor in the clinical picture, but not the whole cause of myasthenia gravis."

In this connection it should be mentioned that, although the tumor we are dealing with showed definite histologic patterns denoting the thymic origin, neither clinical nor pathological examination disclosed findings to support the thymogenic theory of myasthenia gravis. On the contrary this patient had unusually well developed and powerful muscles.

Bell³⁶ reports a benign thymic tumor from a typical case of myasthenia gravis. The tumor was composed of thymic tissue of a fetal type, i.e., dense epithelial reticulum with lymphocytes. He feels that thymic lesions cannot be regarded as the cause of myasthenia since they are present in only about half the cases. Probably the abnormal thymus is due to some more fundamental disorder which is also responsible for the muscle weakness and other features of the disease.

Referring to an underlying fundamental disorder it seems quite likely that a disturbed sex function with hormonal imbalance may play an important part in this disease, being responsible at the same time for a benign tumor of the thymus and the muscular symptoms of myasthenia gravis.

The correlation between the thymus and the sex glands has been established long ago and is of great clinical importance.

The thymus is an organ of internal secretion. Its hypertrophy and involution is in relation to the functioning of other glands of internal secretion such as thyroid, suprarenals and sex glands. The sex glands and the thymus have this distinctive feature in common, that the climax of the inner secretory activity is limited by time. The thymus grows rapidly during childhood until puberty and disappears practically completely after termination of growth. The earlier sex maturity, the sooner the involution of the thymus.

The thymus displays other important functions. It is also a growth organ as is shown from experiments such as feeding tadpoles with thymus substance. Extirpation inhibits growth.³⁷

The abnormal sex and growth function of the thymus had apparently a notable influence on this patient's physical and mental condition and most likely an important bearing on the formation of the mediastinal growth as we shall explain in detail in the following.

In two previous papers the author stressed the close relationship between tumor formation and faulty internal secretion. It was emphasized that rare tumors in mentally sick patients are of special interest, because the same underlying faulty function of internal secretion may be responsible for the mental condition as well as for the tumor formation.

The importance of the influence of disturbed internal secretion on the development of mental disease is nowadays an accepted fact. The pathological view was first advanced by Kraepelin who considered that dementia praecox was primarily due to disordered secretion of the sex glands with injurious consequences to the cerebral neurones. This view was supported by Mott who described changes in the brain cells and pathological changes in the gonads, adrenals and pituitary gland.³⁸

This report presents the third incidence of a rare tumor which developed in a mentally sick patient.

In the first report a case of dysgerminoma was discussed in a patient who was diagnosed as dementia praecox, hebephrenic type. There was strong evidence that the development of this rare tumor was the consequence of disturbed internal secretion, mainly due to arrested sex development.³⁹

The other case report dealt with a patient who suffered from dementia praecox, undetermined type, who shortly after she had entered the menopause developed a growth in the neck region which was diagnosed as carotid body tumor. It was pointed out that since these tumors arise about the period when a physiological regression usually overtakes the gland, some disturbance in the course of the regression may have been an etiological factor.⁴⁰

The patient with whom we are concerned now may be classified under this same category. This may explain: 1. the outbreak of the mental disease, and 2. the development of the tumor.

It is an established fact that patients with a persistent thymus show constitutional inferiority and

extreme lowered resistance physically as well as mentally. A comparatively slight excitement and exertion may cause sudden cardiac death, an acute infectious disease such as myelitis, (Landry's palsy), acute anterior poliomyelitis, meningitis and diphtheria are quite often followed by death. A persistent thymus is often found in patients suffering from diseases of the muscles, from degenerative nerve diseases and with mental diseases, with suicides and with different diseases connected with disturbances of inner secretory glands (Basedow's, Addison's disease, acromegaly, and so on).⁴¹

These observations in patients with persistent thymus in regard to the associated mental and physical abnormalities apply to our case and may explain many puzzling phenomena. They may account for a hormonal imbalance with the subsequent atrophy of the gonads and the outbreak of the mental disease. They may explain the sudden development and growth of the mediastinal tumor following the inner secretory disturbances. The thymus releasing a growth hormone which may have acted on a detached part of the thymus with an enclosed dormant blastomere during the embryonic life may have been stimulated to grow and to differentiate into the varified structures of which this growth is composed. The physical lability especially of the cardiovascular system in patients with persistent thymus may partly account for the sudden unexplained death of this youthful, unusually strong and otherwise healthy individual.

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THE ACTIONS OF RESERPINE

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FOR a period of six months the staff of Stamford Hall has been engaged in a study of the effects of reserpine in an attempt to discern the indications for this new drug in medical practice with special emphasis on its use in nervous and mental diseases.

Our case material includes many of the cardiovascular disorders: benign and malignant hypertension, arteriosclerosis with and without cardiac and cerebral involvement, and old rheumatic hearts. The psychiatric cases encompass nearly the full range of mental disorders except for those due to syphilis and to narcotics. The series includes the chronic brain syndromes due to arteriosclerosis, senility, and alcohol. It includes the schizophrenic, manic-depressive, and psychoneurotic reactions. The neurologic diseases of multiple sclerosis, paralysis agitans, and postlobotomy convulsive disorder were present in a few instances. There were also a number of normal persons who volunteered to take the drug. The series now numbers eighty-eight cases. The study was conducted according to the so-called "double blind" method, wherein those patients who were on reserpine or on the identical placebo were unknown to the observers; and individual patients were shifted to the placebo, also unknown to the observers, as a check on the findings and the reversibility of the drug's effects.

Briefly and to the point, Table I gives the effects of reserpine that we have observed. It is not to be presumed that all cases show all of these findings. In doses above 1 mgm/day the slowing of the pulse, slight lowering of blood pressure, increase in body weight, lethargy, and increased tranquility are fairly constantly observed. By and large the intensity of these effects is proportional to the dose; but beyond a certain point for many of these actions, further increase of the dose produces little further change. The effect on blood pressure, nasal mucosa, temperature, and appetite is about the same in most persons for 2 mgm a day as for 6 mgm. Larger doses are sometimes needed to get the full psychologic effect. It is also true that some persons are much more sensitive to the drug than others.

The lowering of blood pressure, increase in body

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SUMMARY

Reserpine is a physiologic substance, of low toxicity, which seems to have a specific action on the hypothalamus. It is beneficial in a variety of psychophysiologic disorders.

weight, and suppression of agitation are not immediately seen, but take several days to several weeks of administration to make their appearance. This time lag suggests a slow physiologic change, perhaps either hormonal or metabolic. The "improvement" in schizophrenia is given in quotation as we are uncertain as to whether the improvement is secondary to the other observed effects or whether there is a specific beneficial action of reserpine in schizophrenia.

The parallelism between the above recorded effects of reserpine and the known functions of the hypothalamus is close. The hypothalamus is one of the principal centers of homeostatic mechanisms. This portion of the brain serves in the maintenance of a constant internal environment. Both the system of the endocrine glands through the hypophysis, and the nervous system through the action of the hypothalamus on higher and lower nervous centers transmit this homeostatic control to appropriate endorgans. It is in the hypothalamus that the centers of action of the sympathetic and parasympathetic portions of the autonomic nervous system reside. There is a balance between the sympathetic and the parasympathetic and between these two and the many interrelated balances of the endocrine glands. The known actions of the hypothalamus are tabulated in Table II. The anterior hypothalamus might be said to be anabolic and the posterior, catabolic. There is no sharp line dividing these two groups of nuclei (Figure 1) either anatomically or functionally. The middle region (ventromedial nucleus) is important in the regulation of body weight (Figure 2).

TABLE I
CLINICAL EFFECTS OF RESERPINE

NEUROVASCULAR	PSYCHOLOGICAL	GENERAL BODY STATE	NEUROLOGIC
1. Slowing of the pulse	1. Increased tranquility	1. Weight gain	1. Parkinson-like picture
2. Lowering of blood pressure	2. Feeling of lethargy	2. Lowering of temperature	a. Masked face
3. Nasal stuffiness	3. Decreased fear, rage, and anxiety		b. Fine tremor
	4. Increased appetite		c. Appearance of having aged
	5. Increased sense of well-being		2. Increased intestinal motility
	6. Increased self assurance		
	7. Reduction of manic excitement		
	8. Reduction of catatonic excitement		
	9. "Improvement" in schizophrenia		

It can be seen when Table I and Table II are compared that reserpine mimics anterior hypothalamic function. In view of the fact that the anterior hypothalamus is counterbalanced by the opposite action of the posterior hypothalamus, reserpine could be either a stimulator of the anterior hypothalamus or a suppressor of the posterior hypothalamus. The increased sleepiness and drowsiness suggest that reserpine in actuality has a suppressive action on the posterior hypothalamus. This is because there is no known sleep producing center in the anterior hypothalamus, but there is a center for wakefulness in the posterior hypothalamus and this posterior area is in direct association with the reticular formation which is the principal activator for wakefulness. Thus, the evidence from these findings is that reserpine suppresses the functions of the posterior hypothalamus and this suppressive action extends anteriorly as far as the ventromedial nucleus causing increased body weight and posteriorly into the reticular formation causing drowsiness and diminished alertness. In some cases, Parkinson-like signs are observed suggesting an extension of the sup-

pressive action of reserpine into the globus pallidus, a hypothalamic derivative.²

It is therefore possible to interpret the clinical effects of reserpine as being due to suppression of the posterior hypothalamus and its related structures. As this is the same area that is important in mood, feeling, and emotion, it could be expected that reserpine might be beneficial in certain psychiatric cases.

With this understanding of the actions of reserpine it is possible to rationally prescribe the drug for those disorders which show symptoms that are in the opposite direction. The list is long; new indications are turning up all the time—to name a few: manic-depressive psychosis, schizophrenia, anxiety neurosis, "tension headaches," "compulsive scratching," narcotic withdrawal, hyptertension, anorexia, emotional lability, underweight, lower bowel atony. In every instance it is soon found that reserpine benefits only those cases with physiologic or "functional" disorders. Arteriosclerotic hypertension shows little change, while in the "hypertensive personality" a good drop in blood pressure is fre-

TABLE II

ANTERIOR HYPOTHALMIC NUCLEI GROUP		POSTERIOR HYPOTHALMIC NUCLEI GROUP	
NEURAL MECHANISMS	ENDOCRINE MECHANISMS	NEURAL MECHANISMS	ENDOCRINE MECHANISMS
1. Bradycardia	1. Retarded metabolic activity	1. Tachycardia	1. Increased metabolic activity
2. Increased intestinal peristalsis	2. Hypoglycemia	2. Inhibition of peristalsis	2. Hyperglycemia
3. Bladder contraction	3. Insulin sensitivity	3. Dilation of pupil	3. Elevated blood pressure
4. Hypothermia	4. Weight gain	4. Hyperthermia	4. Weight loss
5. Peripheral vasodilatation		5. Peripheral vasoconstriction	
6. Sweating		6. Shivering	
7. Panting		7. Muscular tightness	
8. Parasympathetic activities		8. Sympathetic activities	
		9. Sham rage	
		10. Wakefulness	

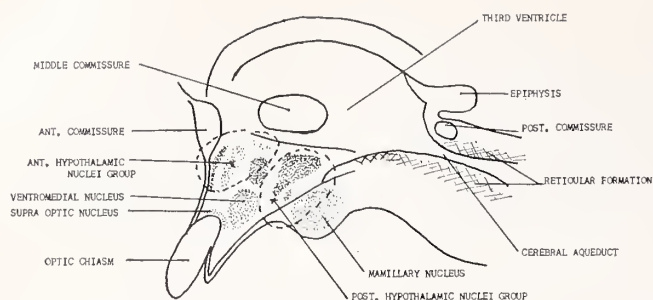


FIGURE 1

Cross section through third ventricle

quently seen. Outside of the psychoses, there seems to be an ill defined, but nevertheless discernible, personality configuration—the “psychosomatic type”—whose symptoms, if they be in the area of reserpine effects, will respond.

It might be worth while briefly to run down the rationale of the use of reserpine in the psychiatric disorders.

1. In the chronic brain syndromes due to arteriosclerosis and senility we are dealing with a disease process that has visible pathological changes. The irritability, agitation, sleeplessness, and aggressiveness seen in many of these patients can be viewed as a release phenomenon wherein the lower brain centers for these activities and emotions (presumably the area of the posterior hypothalamus and related structures) are released from control and balance of higher centers by the disease process. Reserpine suppresses this portion of the brain stem and acts directly to restore the balance and bring about reduced irritability, lessened agitation, easier sleep, and greater tranquility.

2. In the manic and anxiety states reserpine serves to suppress the prominent symptoms of these disorders: hyperactivity, insomnia, weight loss, anorexia, irritability, and increased metabolic activity in the instance of the manic patient; and fear, restlessness, uneasiness, rejection of food, and difficulty in getting to sleep in the anxiety states.

3. In schizophrenia, reserpine may or may not assist in controlling the symptoms. Above and beyond the symptomatic effects, it seems that reserpine lessens the autogenous emotional pressures and reduces the vulnerability to external stress. This effect allows some schizophrenics to get a hold of themselves, so to speak, and re-establish themselves

in reality. At present there is no known way of determining which schizophrenic patient is most apt to respond favorably. No severely withdrawn or deteriorated patient in our series has improved sufficiently to go to the open service. Those who have done well preserved an emotional responsiveness, albeit sometimes a negative one, in their illness. Reserpine is not a cure for schizophrenia, and in many cases is less effective than the already established therapies of electroconvulsion, insulin coma-psychotherapy, and psychosurgery.

It has long been observed that patients with manic-depressive illness, involutional reaction, and some schizophrenics, gain weight coincident with improvement in their mental state. Electroconvulsion and insulin coma both cause a weight gain in most patients. We have been interested to observe that normals, manics, and schizophrenics (depressives did not benefit much by reserpine) all gained weight on reserpine; however, improvement in mental state did not necessarily occur in these patients.

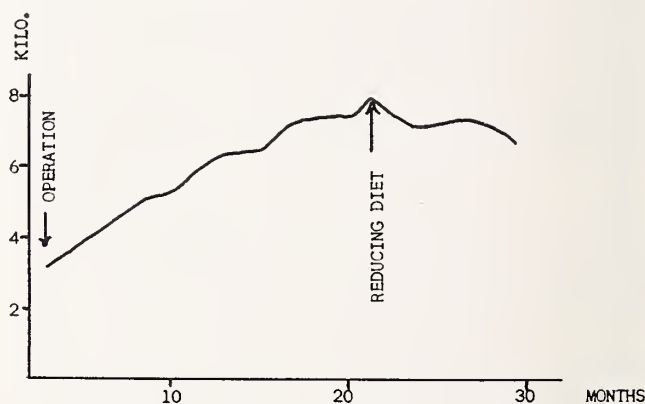


FIGURE 2

Graph showing weight gain of a cat which became obese following a lesion in the region of the ventromedial nucleus of the hypothalamus¹

CONCLUSIONS

Reserpine is a physiologic substance of low toxicity which it seems safe to presume has a nearly specific suppressive action on the posterior hypothalamus and related structures. It can ameliorate or reverse the symptoms in a large number of psychologic and physiologic disorders. The diverse actions of reserpine make sense when the neurophysiology of the hypothalamus is kept in mind.

The reserpine used in this study was provided by E. R. Squibb and Sons under the trade name, Rau Sed.

The entire staff of Stamford Hall contributed to this research. Particular acknowledgment is due to Drs. Clifford D. Moore, Gustaf Blass, and Adrian C. Moulyn for their kind assistance.

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BELL'S PALSY TREATED WITH CORTISONE

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ETIOLOGY

Bell's palsy, differentiated from the more general term of facial paralysis, has been considered a sequela of exposure to cold or to wind. A statement often obtained from a patient is to the effect that he went to bed feeling perfectly well, only to awaken with one side of his face paralyzed. Another cause, although less common, is geniculate herpes usually characterized by severe pain and vesiculation.

TREATMENT

Although Walshe¹ feels that some cases of Bell's palsy may clear spontaneously in three to four weeks, he recognizes that the majority tend to persist for from three to twelve months or may even be permanent. Treatment has presented a problem to otolaryngologist, neurologist, and family physician alike. For the most part it has consisted of heat, massage, electric stimulation, vasodilators and vitamins with varying results. Some have even advocated the formidable procedure of early surgical decompression of the nerve as it passes through the bony canal.

USE OF CORTISONE

In 1953 Rothendler² published his results of the treatment of this condition with cortisone. He obtained complete recovery within ten to fourteen days in seven out of eight patients treated within nine days of the onset. Failure he considered to result from too long a lapse of time after the onset, with resulting failure of the nerve to respond to faradic stimulation. He used decreasing dosages from 600 mg. to 50 mg. daily. Robinson and Moss³ in

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SUMMARY

A case of Bell's palsy treated with cortisone is presented. It is the author's hope that a larger series of cases will be published in the future in order that this new method of therapy of an oftentimes discouraging condition may be fully evaluated.

January, 1954 reported two additional cases with similar findings and similar results. In August, 1954 Bernstein⁴ published the findings in another patient who received from 150 mg. to 50 mg. in six succeeding days, resulting in complete recovery in seven days.

CASE REPORT

A 39 year old housewife was first seen on September 18, 1954 with the history of scratching her left exterior auditory canal with a hairpin the previous day. That same night she had throbbing pain, a slight chill, and a blocked ear. This was not relieved by self administered warm oil. There was no vertigo nor tinnitus.

Examination revealed a diffusely swollen, tender left auditory canal. The drum could not be seen. There was no evidence of rash, vesiculation or edema in the surrounding area. There was no sensory or motor loss. Taste was not tested.

A cotton wick was saturated with Cresatin (R) inserted into the canal and kept moistened with the same solution. The pain and swelling disappeared in 48 hours, but there was some feeling of numbness around the ear. She returned

next on September 21 at which time both the canal and the drum were completely normal. However, she showed a complete peripheral facial paralysis: inability to raise left eyebrow or close left eye, extreme epiphoria, loss of nasolabial fold, and inability to whistle or raise left corner of the mouth.

Treatment was started with nicotinic acid, 50 mg. t.i.d. a.c., and continued for one week. She noted the flushing response but there was no change in the paralysis. The therapy was then changed to cortisone, 25 mg. daily for seven days. After two days she felt a return of sensation, and at the end of six days she could close her eye, wrinkle her forehead and whistle. There was about a ten per cent residual paralysis. The same dosage was continued for four more days with resulting complete recovery. One month later she showed no evidence of paralysis.

COMMENT

The occurrence of the acute external otitis may

have been the etiological factor or simply a coincidence in this case. Whether this particular case may or may not have cleared spontaneously cannot be ascertained, but experience has shown that it is the rare patient who recovers so rapidly and so completely.

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A MODIFICATION OF THE WATER-BOTTLE HUMIDIFICATION APPARATUS

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AN effective means of humidifying oxygen is to bubble it through warm water. The widely used, classical water-bottle mechanism presents certain disadvantages:

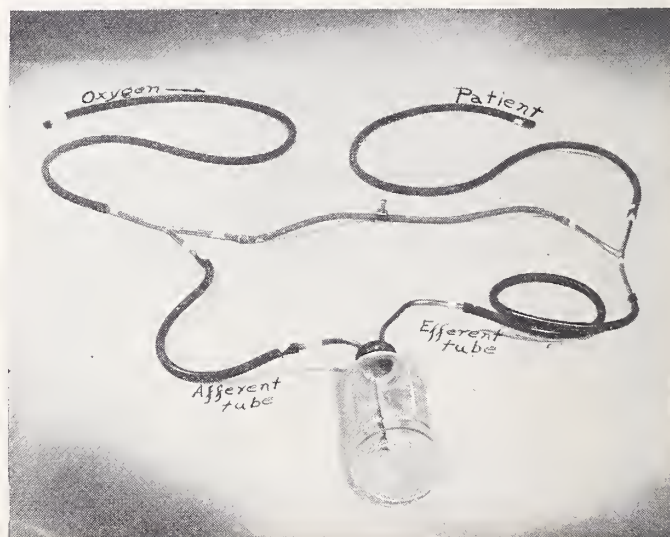
1. It is not possible to replace evaporated or add warm water without interrupting the oxygen flow.
2. It is not possible to control humidity without altering oxygen flow.

In recent years there has been extensive exploration of the beneficial effect of heavily humidified atmosphere in the prevention and treatment of abnormal respiratory states of the newborn; and the harmful effects of unhumidified oxygen have long been recognized. The disadvantages of high oxygen saturation (or too prolonged oxygen therapy or too sudden cessation of oxygen) in producing serious eye disease in prematures, as well as the possible disadvantages of "mist therapy" in predisposing to skin maceration and possible *Pseudomonas aeruginosa* infections are outside the scope of this presentation and are mentioned only to give perspective to the possible utility of the apparatus to be described.

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SUMMARY

A simple homemade modification of the water bottle oxygen humidifier is described.



The purpose of this paper is to describe a simple modification of the water bottle apparatus, which increases its flexibility and versatility.

NOTES ON THE APPARATUS

As pictured, the apparatus utilizes the conventional rubber tubing, a 500 cc. vacoliter flask with openings in the rubber stopper enlarged to accommodate two ¼ inch copper tubes. The afferent tube is perforated and the immersed end is closed with solder. The efferent tube does not extend more than an inch into the bottle to avoid bubbling over. The Y tubes are also constructed from ¼ inch copper tubing.

The complete character of this modification consists, then, of a rubber hose which bypasses the water bottle.

When this tube is compressed by the thumb screw

all the oxygen bubbles through the water and as this bypass is opened, less traverses the water jar.

To add warm water or wetting agent to the jar without stopping oxygen flow the bypass tube is opened and the afferent and efferent tubes clamped together.

In administering oxygen via nasal catheter, face mask or celluloid cone, particular caution must be exercised to be certain that the efferent tube is high enough above the water level to prevent bubbling over and, more important, particular care must be exercised to be sure that the tubing going to the patient is not accidentally attached to the afferent or immersed copper tube.

The applicability of this device would seem to be considerable in catheter or mask administered oxygen.

A NEW DIRECTION IN HEALTH INSURANCE

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MAJOR medical expense insurance contains the seed of an idea that may give new direction to health care insurance. The idea: Budgeting.

This new kind of insurance—in many respects still in the experimental stage—works on the following principle: people should insure against the big, unpredictable costs of illness or accident. The small, routine, almost foreseeable costs can be paid out of current budget by the average person more economically than through an insurance mechanism.

Major medical insurance is the broadest form of health insurance yet devised. It is designed to protect against the long-term catastrophic illness or disability—paying benefits, for example, on such unusual things as cancer and special nursing.

If enthusiastic reception of the idea continues, the relationship of health insurance to health care payment may result in some new concepts. This is contingent on many unpredictables. The attitudes

and reactions of the following groups will be significant.

THE INSURERS

Insurance companies, and now Blue Cross-Blue Shield, are building necessary statistical experience in the field of major illness expense. It will take three to five years before reliable statistical information will be in sufficient quantity to properly judge its accuracy.

Prior to the introduction of this new plan six years ago, some companies had conducted limited experiments in the major medical or catastrophic insurance area, but no one had gone into the field extensively. In 1949, Liberty Mutual Insurance Company was approached by the Elfun Society, a General Electric management group, for protection against medical bills not adequately covered by the usual type of hospital and surgical plans. Ninety per cent of the Society's 2,400 members enrolled in the experimental plan that was developed.

From these beginnings, the number covered in the U. S. has grown to 1.5 million persons. Over 75

insurance companies now are offering major medical expense policies, on a group or individual basis.

Although there is considerable variation, almost all plans written today have common features. They have a fixed top limit of anywhere from \$2,000 to \$10,000, with the most common figure \$5,000.

There is a deductible (same principle as automobile collision insurance) that ranges from \$200 to \$1,000, depending on the policy and the amount of the maximum benefit limit. And there is coinsurance, usually of 20 or 25 per cent.

A TYPICAL PLAN

One typical plan that combines all these features would work like this: A person has a total bill of \$4,205. He has a major medical policy with a \$500 deductible, \$5,000 maximum and 25-75 per cent coinsurance. After the \$500 deductible, 75 per cent of the bill still comes to \$2,779, which the insurance company pays. The policyholder would be liable for \$1,426.

In many cases the initial deductible amount would be taken care of by the basic hospital-medical-surgical coverage (many companies require it before writing a major medical policy).

When this basic coverage is incorporated in the complete health care package of the employer, it is often the practice of the insurer to require a "corridor amount." This is the responsibility of the individual. The corridor comes between where the basic coverage limits leave off and the major medical coverage commences.

The reason for deductibles, coinsurance and corridors is to encourage the individual to take some financial self interest in keeping the cost of care to a minimum consistent with good treatment and fast recovery.

When group major medical is superimposed on the basic coverages, the result is often a somewhat complex package. With individual major medical contracts, the program is sometimes not too easy for an average person to comprehend. Furthermore, the budget incentive, although present, is usually not highlighted. This de-emphasis can result in a family's misunderstanding of the family budget and insurance working together to meet health care costs.

Realizing this, a few insurance companies have just recently begun to explore a deviation of the major medical expense theory. This could be the most significant health insurance development since

the introduction of major medical itself. These companies have commenced writing integrated basic major medical policies that more strongly emphasize the budgeting idea and eliminate the complexities of the superimposed plan.

One company has just begun selling group coverage with a \$5,000 top limit and an initial deductible of \$25, \$35, \$50, or \$100. After the initial deductible, the charges for the next \$500 or \$1,000 are paid in full or a 75 per cent coinsurance feature goes into effect—whichever the policyholder wants.

Another company writes a plan with a top limit of \$5,000 and a deductible of \$50. There is no general coinsurance requirement, although the principle is applied to several specific benefits. For example: 90 per cent of hospital benefits, 50 per cent of special nursing, 75 per cent of prosthetic appliances, and so forth.

THE PROVIDERS OF MEDICAL CARE

Perhaps some of the most important public influences on the future development of major medical insurance and the augmented budgeting idea will be the attitudes of doctors and hospitals.

Medical practitioners and hospital groups have been staunchly behind the development of prepaid methods of health care. Hospitals have more generally favored the underwriting of plans providing service benefits. Many doctors, however, feel the cash indemnity approach better preserves the important physician-patient relationship, and the free choice of doctor principle.

Doctors and hospitals have watched the health insurance movement grow with changing emotions. When Blue Cross started, many hospital people welcomed it as a means to alleviate the financial distress of people who could not pay lump-sum hospital bills.

Some students of health insurance in the hospital field today are advocating the insurance or prepayment mechanism be geared to the full payment of hospital bills, no matter what they might be. There are a number of reasons for this. Perhaps one of the most important, however, is the impact which voluntary health insurance has made on hospital income.

In Chicago, it is estimated, 70 per cent of all the hospitals' income comes from third party sources, like insurance companies and service plans. Group insurance companies alone are estimated to be paying 20 per cent. Doctors, too, are finding a growing

portion of their income stemming from health insurance payments.

Traditionally, physicians have charged people according to the seriousness of the case and the patient's ability to pay. It is a paradox that insurance seems to increase the ability to pay. Actually, it does not.

THE PURPOSE OF INSURANCE

The purpose of insurance is to provide timely benefits in sufficient amount to prevent the cost of ill health or accident from spelling financial hardship to individuals and families who might otherwise suffer such hardship. Insurance is a prepayment method. The insurance mechanism does not add any funds. It simply holds the premiums of a group of people and pays them out when benefits are needed. Higher medical charges this year cause higher premiums next year. In this way the premium price could be forced right out of the market.

Major medical insurance can become a blank check to be filled in by the providers of health care. The dependency on health insurance by the providers for a greater part of their income, a desire on the part of some for first and last dollar coverage, and a tendency to regard insurance as a means to increase ability to pay are factors that promote such a situation.

The safety checks in major medical contracts are not foolproof. As the coverage increases and the health care profession becomes more familiar with it and its purposes, the ensuing understanding and cooperation grows in importance.

Current interest in major medical on the part of doctors and hospital people is blossoming into enthusiasm. As this continues, the insurance budgeting idea will grow in importance. Factors that would tend to have a toxic effect on major medical will lose their sting.

LABOR AND MANAGEMENT

The dynamic forces at play in an industrial society have had a great deal to do with the development of major medical expense insurance thus far. They will have an important bearing on its future success.

An estimated million and a half people are covered by major medical expense insurance. Of this, more than a million are covered by group major medical—mostly through employee-employer plans. This figure is twice what it was a little more than a year ago.

This growth is all the more remarkable considering some of the health care payment wishes labor leaders have expressed in the past.

Much of organized labor so far has wanted plans that provide almost total benefits.

Until recently insurance companies and employers were reluctant to extend benefits to lower salaried employees.

Yet at the present time an increasing number of hourly wage employees and their dependents are being included in this coverage. Labor leaders are talking of the coverage in terms of an important new fringe benefit.

Because the employer will undoubtedly be asked to pay a greater share of the premium as time goes on, he will have an amplified voice in the patterning of the coverage. Already, insurance companies report considerable employer interest in group insurance that integrates basic coverage with major medical and encourages initial budgeting by the employee for small items.

The speed and effectiveness with which insurance companies and employers can streamline and simplify the whole health insurance plan package will have much to do with the continued success of the voluntary health insurance movement. An employee wants a fairly accurate idea of how deep he'll have to dip into his own pocket when accident or illness strikes. As a tempting alternative he is attracted to closed panel medicine or a comprehensive union-company sponsored and supported clinic.

GOVERNMENT

The present administration has taken a stand favoring the extension of voluntary health insurance. Major medical is one of the items being given special emphasis.

Many insurers believe major medical and other coverages are being extended as rapidly as they can. The government wants the process hurried up.

Previous administrations have favored more socialized approaches to health care financing. These ideas or variations on them may again be put forward. President Eisenhower has the laudable conviction that increased voluntary protection, including major medical, will serve as a bulwark against social medicine schemes.

The government's concern is logical. Federal statisticians have reckoned the country's total annual medical bill to be \$10-11 billion. A number of insur-

ance leaders, however, contend that this figure contains too many noninsurable items. By assuming the general need for more major medical coverage, the government is faced with some difficult questions:

Can the idea be encouraged by legislation without stifling initiative?

Can all types of insurers be given equal opportunity?

What "standards" are necessary?

How strongly can the budget idea be advanced in opposition to those who would have comprehensive or even socialized care?

Is there really a need for federal intervention?

The answer to these and other questions is part of the key to the future pattern of major medical and the budgeting idea.

The public in the long run has benefited from competition between providers of health insurance. New types of coverage are constantly being developed. Existing coverages are being broadened. Contrasting philosophies of indemnity and service benefits have speeded extension of coverage to more and more people.

Yet the experimentation necessary to put a new type of insurance like major medical on a sound footing leads to a sometimes confusing welter of variations on the main theme. There is little actuarial experience available to a company when it enters the field.

Eventually this experimentation will lead to a more or less standardized pattern of major medical insurance. In the meantime, many new ideas will be tried out. The right combination of successful

ideas will be the basic ingredient of the future major medical policy.

Desires of the public will exert strong pressure in the development of the future contract. The idea of budgeting—although growing in popular acceptance—has not yet achieved enough prominence to successfully challenge the concept of comprehensive care. The sympathy the public affords one or the other of these ideas will be another important factor in the future development of major medical.

Those individuals sympathetic to the budgeting principle want to know more accurately the amount they should budget for medical expenses over a period of a year. Many seem to want one policy for all health contingencies. They want elimination of areas where benefits of several policies may not quite meet, causing difficulty in forecasting out-of-pocket costs.

The public wants a major medical policy that will not go out of date quickly. In a similar vein, the terms of the contract must be broad enough to keep pace with medical advance. New medical treatment, techniques and procedures must be covered as developed.

Most Americans want to preserve the traditional relationships with the providers of medical care. A national opinion research group reports a decided drift away from the idea of socialized medicine.

Major medical expense insurance as it stands today is partially or completely meeting many of these aspirations of the public at large. The future pattern of insuring against health care costs will be strongly influenced by two factors: the continued success of the major medical principle and the extension and integration of such major medical concepts as budgeting.

THIRTIETH CONNECTICUT CLINICAL CONGRESS

of the

CONNECTICUT STATE MEDICAL SOCIETY

and the

YALE UNIVERSITY SCHOOL OF MEDICINE

YALE-NEW HAVEN MEDICAL CENTER

September 14, 15, 1955

The 1955 Clinical Congress will be presented in two days and all of the meetings will be held at the Yale-New Haven Medical Center.

Two sessions will be held simultaneously in different auditoriums giving a broad selection of topics. Material in the fields of diabetes, cardiovascular disease, biliary tract surgery, poliomyelitis, hepatitis, new drug therapy, clinicopathological conferences, and other related subjects will be presented.

Registration admitting to all sessions will be \$3. Medical students, interns, and residents will be the guests of the Congress, if properly certified. Cafeteria luncheons will be available.

MAKE A NOTE OF THESE DATES ON YOUR CALENDAR

Preliminary Program
THIRTIETH CONNECTICUT CLINICAL CONGRESS
WEDNESDAY, SEPTEMBER 14, 1955

9:30 REGISTRATION

BRADY AUDITORIUM

H. M. Marvin, *New Haven, presiding*

- 10:00 CLINICAL ASPECTS OF DISORDERS OF COAGULATION
 Mario Stefanini, *Brighton, Massachusetts*
- 11:00 ANTICOAGULANTS
 11:00 William T. Foley, *New York*
 11:30 Henry I. Russek, *Staten Island, New York*
 12:00 Discussion
- 12:30 LUNCHEON
 Frederick W. Finn, *Greenwich, presiding*
- 2:00 HYPOPHYSECTOMY FOR BREAST CANCER
 Speaker to be announced
- 2:45 CHEMOTHERAPY OF NEOPLASTIC DISEASE: ITS RELATIONSHIP TO SURGERY
 Joseph H. Burchenal, *New York*
- 3:30 CHANGING CONCEPTS OF CANCER SURGERY
 J. Englebert Dunphy, *Boston, Massachusetts*
- 4:15 Adjournment

WEDNESDAY, SEPTEMBER 14, 1955

9:30 REGISTRATION

FITKIN AMPHITHEATER

Barnett Greenhouse, *New Haven, presiding*

- 10:00 USE OF VARIOUS TYPES OF INSULIN
 David Hurwitz, *Cambridge, Massachusetts*
- 10:45 USE OF FRUCTOSE IN TREATMENT OF DIABETIC ACIDOSIS
 Max Miller, *Cleveland, Ohio*
 Roy N. Barnett, *Norwalk, presiding*
- 11:30 CLINICOPATHOLOGICAL CONFERENCE
- 12:30 LUNCHEON
- 2:00 PANEL ON LOW BACK PAIN
 Moderator: Ettore F. Carniglia, *Hartford*
 Charles O. Bechtol, *New Haven*
 Preston N. Barton, *Meriden*
 Morton Marks, *New York*
 Louis Linn, *New York*
- 3:15 PANEL ON HEADACHE
 Moderator: Gilbert H. Glaser, *New Haven*
 Arnold P. Friedman, *New York*
 Theodore Lidz, *New Haven*
 Speaker to be announced
- 4:30 Adjournment

THURSDAY, SEPTEMBER 15, 1955

9:30 REGISTRATION

BRADY AUDITORIUM

- 10:00 PANEL ON INFECTIOUS HEPATITIS
 Moderator: John R. Paul, *New Haven*
 ROLE OF CHRONIC CASE AND BLOOD DONORS
 John R. Neefe, *Philadelphia, Pennsylvania*
 DISSEMINATION
 Joseph Stokes, Jr., *Philadelphia, Pennsylvania*
- 11:15 PANEL ON IMMUNIZATION AGAINST POLIOMYELITIS
 Speakers to be announced
- 12:30 LUNCHEON
- 2:00 PANEL ON DRUG THERAPY IN HYPERTENSION
 Moderator: C. Louis Fincke, *Stamford*
 Speakers to be announced
- 3:15 PANEL ON NEW TRANQUILIZING DRUGS
 Moderator: John Donnelly, *Hartford*
 Paul H. Hoch, *New York*
 Nathan S. Kline, *Orangeburg, New York*
- 4:30 Adjournment

THURSDAY, SEPTEMBER 15, 1955

9:30 REGISTRATION

FITKIN AMPHITHEATER

Hugh L. Dwyer, *New Haven, presiding*

- 10:00 INTRACTABLE HEART FAILURE: ITS MANAGEMENT
 E. Hugh Luckey, *New York*
- 10:45 PERIPHERAL VASCULAR DISEASE
 Fiorindo A. Simeone, *Cleveland, Ohio*
- 11:30 CLINICOPATHOLOGICAL CONFERENCE
 Ralph E. Kendall, *Hartford, presiding*
- 12:30 LUNCHEON
 William J. Curley, Jr., *Bridgeport, presiding*
- 2:00 COMPLICATIONS OF BILIARY TRACT, SURGERY AND THEIR TREATMENT
 Speaker to be announced
- 3:00 INDICATIONS FOR EMERGENCY SURGERY IN BILIARY TRACT DISEASE
 3:00 Henry Doubilet, *New York*
 3:30 Speaker to be announced
- 4:00 PANEL DISCUSSION—BILIARY TRACT SURGERY
 Henry Doubilet, *New York*
 Speakers to be announced
- 4:30 Adjournment

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

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EDITORIALS

The Clinical Congress

The Connecticut Clinical Congress was first held in 1925, and each year save one since then, it has been presented to the physicians of Connecticut and neighboring States. In the beginning it served a keenly necessary purpose, was well received, and copied in one way or another by several States. During the 30 years that have passed since then, the opportunities for brief postgraduate educational experiences and refresher courses have increased so rapidly that it is difficult to keep track of them. They have all been competition for the Clinical Congress, and although the committee arranging the programs each year has tried diligently to present up-to-date material of broad interest, attendance at the Congress has declined to the point where the question has been raised if it should be continued.

Last year the Committee on the Clinical Congress tried to determine by questionnaire to all members of the Society whether they wished it to go on. The result of this questionnaire was not illuminating, but when it was reported to the House of Delegates at the 1955 Annual Meeting the House voted that it should be continued.

The Committee, under the chairmanship of Arthur Ebbert, Jr., assistant dean of postgraduate medical education at Yale Medical School, is now arranging the program and the dates are September 14-15. Although it is realized that this is just at the end of the vacation season, it is the only time that does not conflict with the medical school program; it is just before classes start.

Inquiries were made about holding it in another place but this was found to be impracticable.

As in the past, the material presented will be selected with a view of interesting everyone, general practitioners and specialist alike, and you are urged to attend, it is for you!

The future of the Congress depends largely upon the response this year.

Automobile Crash Injuries

"Safety engineers say that until you demand as much safety as style in your automobile—until you convince manufacturers that you'll buy autos with such possible innovations as pullout panels, crash bars and seats designed for greater safety—your best bet against death or injury is the simple safety belt fixed to the frame of your car. That's a fact—scientifically tested and proven." These are the closing words from an Associated Press dispatch from Buffalo by George Bzan and quoted in the *Bulletin of the American College of Surgeons* (40:3, May-June, 1955).

As reported in the December 1954 issue of the *CONNECTICUT STATE MEDICAL JOURNAL*, Connecticut is one of four States in which the Cornell Auto Crash Injury Research project is being carried out to obtain, for the first time, information concerning the specific causes of injuries and deaths in a representative sample of passenger car accidents. These accidents represent a medical problem of epidemic proportions.

Horace E. Campbell, M.D., of Denver, chairman of the Automotive Safety Committee of the Colorado

State Medical Society, supplies a series of cases in the *Bulletin of the American College of Surgeons* where serious, often fatal injuries were apparently prevented by the use of safety belts built in to the automobile seat. These cases are extremely thought provoking. To quote only one of them will suffice. "Blinded by oncoming headlights, a 49 year old woman driving a 1954 Austin-Healy at 60 miles an hour on a 40 mile per hour mountain highway swerved part way up an embankment on her side of the road, came down and crossed the highway, and rolled 45 feet down the embankment on the other side. The car was damaged to the extent of \$2,000, but the driver was not injured at all."

One of the conditions contributing to fatal injuries is the opening of doors in an accident with the resulting ejection of the occupants. This situation has been found to double the occurrence of fatalities. Other causes of injury are the instrument panel, the windshield, the steering mechanism, door structures and hardware. We shall watch with interest for the result of this research project.

Dr. Campbell's brief for the use of the safety belt is very convincing. He recommends that after a safety belt has been installed, the next thing for one to do is to sit down and write one's automobile manufacturer, informing him he would like all of the eight following specifications carried out in the next car he purchases:

1. Seats in which the adjusting mechanism is constructed so strongly that they can withstand sudden stops equal to 40 times the pull of gravity.
2. Retractable, built-in seat belts as a feature of that kind of seat.
3. Doors built like an airplane door, that will not pop open at any impact under 40 G's.
4. A crash panel of four-inch-thick foam material like vinyl foam or Ensolite (foam rubber is too soft) replacing the instrument panel on the right two-thirds of the car, from windshield to floor.
5. A plastic windshield, glass coated on the outside to resist abrasion, which will stretch from four to eight inches on impact and thus prevent fatal injury.
6. Steering column with a broad energy absorbing pad on the top, and equipped with shear pins or an inertia lock, to absorb energy upon impact.
7. "Crashlining" of all levers, projections, rearview mirrors, et cetera, and padding on the windshield header.
8. A front nose, two and one-half feet thick, made

of something like aluminum foam which would crumple slowly, absorbing the shock of a crash—our present bumpers are a farce, and the present design makes the whole front end of the car a bumper, a very expensive arrangement.

The Chiropractic Veto

"We would be remiss in our public responsibility if we did not urge you to veto SB1181, Definition of Practice of Chiropractic." These were the opening words of a memorandum sent by the President of the Society to Governor Ribicoff immediately after the bill had passed the House and Senate in May.

SB1181 was an apparently innocuous bill to amend Section 4386 of the General Statutes that defines the practice of chiropractic. Careful study of the measure disclosed that it was vaguely written and held implications of broad extensions of the privileges of chiropractic.

The Society used its best efforts to obtain unfavorable action by the Committee on Public Health and Safety but the Committee reported it favorably and it was bucked through the House and Senate by the Senate chairman of the Committee on Public Health and Safety, himself a chiropractor.

When the hazards inherent in the bill were brought to the Governor's attention in the Society's memorandum, he became concerned immediately and called a conference with representatives of chiropractic and from the State Medical Society. The subject was discussed with frankness and the elements of sophistry in the act were uncovered. Soon after this conference the Governor announced that he would veto the measure as being "vague and uncertain." Under the circumstances of the bill's origin, it was a courageous step in the public interest on the part of the Governor and by the veto the pretenses of chiropractic are punctured and deflated.

Empire Citizen

A physician who becomes the president of the national medical organization in a great country must have certain special qualities. Among these are unselfishness, ambition, integrity and political intelligence. When a man becomes the president of the national medical organization in two great countries at the same time, he needs special qualities indeed. Such a person is T. C. Routley of Toronto. Dr. Routley was installed as President of the British Medical Association on Monday evening, June 20,

with appropriate pomp and circumstance in the presence of physician representatives from the far flung British dominions. The badges of office were presented by Sir John McNee of London, the retiring President and to the President's lady, Mrs. Routley, by Lady McNee. On Wednesday evening June 22, in a simpler ceremony, Dr. Routley was installed as President of the Canadian Medical Association. It was the fourth time in history that the British Association had met in Canada.

After returning from a distinguished career in World War I, Dr. Routley became the secretary of the Ontario Medical Association, an office which he held for a few years and then moved to become the secretary-general of the Canadian Medical Association. As such he has been a familiar figure at many meetings of the American Medical Association and made a host of friends. The Canadian Association grew and prospered under his guidance and immediately when he retired he was elected President-Elect of the Association. Dr. Routley has held important portfolios in international medical affairs; with the United Nations, World Medical Association and others. He and Mrs. Routley travel widely and are at home everywhere. He is truly an Empire Citizen and his warm friends in Connecticut extend him best wishes and congratulations to the Medical Associations of Great Britain and Canada for this choice of their leader.

The Osteopath

Probably one of the best examples of democracy in action occurred at the recent annual session of the House of Delegates of the American Medical Association in Atlantic City. Following the proposal of John W. Cline of San Francisco in his presidential address before the House in 1952 that a study be made of the relationship between regular medicine and osteopathy with a view to improving the education of students in osteopathic schools, a special committee was appointed to implement this proposal. This eventuated in the on-campus study of five of the six osteopathic schools with the full cooperation of the American Osteopathic Association. The report of these observations together with recommendations were brought to the House of Delegates at this Atlantic City session and referred to a reference committee of the House.

There was a difference of opinion, a healthy event when arrived at by intelligent minds acting in sincere good faith. The majority report of the reference committee, although not "completely satisfied

that the current education in colleges of osteopathy is free of the teaching of 'cultist' healing," recommended a closer liaison with osteopathic schools to allow physicians to teach in such schools. It left the solution of the relationship between doctors of medicine and doctors of osteopathy to be solved at the local level by the various state medical associations.

One member of the reference committee had the intestinal fortitude to make a minority report couched in such forceful and convincing terms that it was adopted by the House. This physician said he believes osteopathy is still a "cult" and that its teaching in osteopathic schools is that of "cultist" healing. He could not subscribe to the teaching by doctors of medicine in osteopathic colleges where "cultism" is part of the curriculum, hence he proposed that the whole problem be dropped until such a time as the American Osteopathic Association shall abandon the "osteopathic concept" from its colleges and shall request of the Trustees of the American Medical Association further discussion of the relations between Osteopathy and Medicine.

That is where the osteopath stands today in relation to the doctor of medicine. There are some who say we never should have become involved in this controversy. Perhaps so, but the situation existing in the different 48 States varies so that the physician in California may rightfully look upon the problem with a far more friendly eye than the physician in Nebraska. The three delegates from Connecticut did not view the problem eye to eye. Several editorials on the osteopathic problem have appeared in the JOURNAL during the past two years and in at least one of these the opinions of our members were solicited. The three delegates went to Atlantic City uninstructed, in fact, very few members ever took the trouble to express to any one of their delegates just how they viewed this controversy.

The answer has not yet been found. We do know more about the osteopathic colleges, but what about our friends who we know in good faith are occupying teaching positions in these cultist colleges? And what about the physician—and there are many—who consults with osteopathic physicians where he believes it is for the good of the patient?

The issue is not a dead one by any means. More will be heard about it and a prophetic note might even be added that the day will come when osteopathy will go the same way that eclectic medicine and homeopathy have gone. In the meantime one must follow the dictates of his own conscience.

Ethics is the science of moral duty, and in the case of the practice of medicine that duty is to the patient.

A Golden Anniversary

AS OUR OWN JOURNAL enters upon the twentieth year of its existence we pause to pay tribute to a sister publication which with its June, 1955 issue celebrated its 50th anniversary, the *Journal of the South Carolina Medical Association*. One cannot read the account of the early beginnings of that publication without realizing what a struggle some of our State medical associations experienced in their ambitious attempts to go forward. In 1900 when President Porcher of Charleston, South Carolina, in his presidential address recommended the establishment of a medical journal by his State Association, that organization boasted a membership of 150 with annual dues of three dollars "and no money to speak of in the treasury." Five years later when this suggestion was finally acted upon the Association had only \$262.22 in its treasury and South Carolina was one of the smallest States in the Union to undertake such a publication.

The story is all there—almost to the blood, sweat and tears—and today the physicians of the Palmetto State can look with pride upon their Journal. Its pages speak volumes for the loyalty and perseverance of its editors over the half century—Robert Wilson, J. W. Jervy, F. H. McLeod, J. C. Sosnowski, Edgar A. Hines, Julian Price, and now Joseph I. Waring. To live among these people of our Southland is to respect them and to love them.

The *Journal of the South Carolina Medical Association*, at your prime of fifty years, we salute thee!

Some Remarks on the Spread of Infectious Diseases With Comments on Epidemic Pleurodynia

"Every pain has its distinct and pregnant significance, if we will but carefully search for it."

JOHN HILTON

The history of epidemics is an interesting one. When I was a student some sixty-odd years ago there was no widespread epidemic poliomyelitis in this country, in fact, only two or three localized outbreaks had been noted. We saw occasional sporadic cases in the clinics, always in children and always with paralyses. No doubt, in the light of present knowledge, there were nonparalytic cases

that passed unrecognized. The disease was first clearly described by Underwood in 1784, but no epidemics were recorded until the beginning of the fourth quarter of the nineteenth century. Some of these preceded or followed outbreaks of influenza, and one may conjecture whether possibly the association of these two virus diseases was perhaps a factor in enhancing the virulence of the virus of poliomyelitis and in transforming infantile paralysis from a sporadic to an epidemic disease. During the present century polio has become not only perennially epidemic but is no longer a disease of childhood alone for many adults are attacked.

The preceding discussion suggests several questions anent the epidemiology of infectious diseases, of which poliomyelitis is cited merely as an example: Are the epidemic diseases which we now recognize new diseases or are they simply old afflictions which have become widespread because of certain situations? If the latter is the case, what are the conditions which favor the transformation of an endemic infection into an epidemic one? One naturally thinks of situations which affect the two basic factors in any infection: the etiological agent and the infected individual. It is clinically obvious that in all infectious diseases there is some variation in the virulence of the causal agent in different outbreaks. We have seen malignant syphilis and malignant measles and, in the case of syphilis, also forms so mild that it is difficult to picture them as the same disease. Just what causes apparently sudden accentuations in virulence in a given infection is not always clear. So far as individual resistance is concerned, war with its accompanying semistarvation and resultant reduced resistance in some areas doubtless is an important factor. The persistence of an infection among groups of people for generations seems to favor increased individual resistance, as witness the virulence of measles, for example, when introduced into new territory as contrasted with the same disease among peoples long subject to it. Then too in modern times the opportunities for the spread of infections, due to much more rapid methods of travel, have been greatly increased. There is clear evidence that many diseases once localized, undulant fever or Q fever, for example, have been carried by persons traveling from infected to uninfected areas. Where living vectors are involved in transmission their presence is obviously necessary to produce epidemicity.

The question of epidemic pleurodynia seems worthy of special consideration because knowledge

of its occurrence and clinical picture has not been sufficiently widespread among the profession. Nichamin* has recently called attention to it again and has emphasized that it is a form of infection due to the Cocksackie virus. Pons and Valenti in Spain† have also emphasized its etiology. The disease has never been very widespread in this country though Dabney described an epidemic in Virginia in 1888, Reilly noted small groups of cases in 1899 and again in 1921, and Locke and Farnsworth recorded a college epidemic in Williamstown, Massachusetts in 1935.

The disease has been known under a variety of names: myalgia epidemica, devil's gripe, Bornholm disease, epidemic transient diaphragmatic spasm, and epidemic diaphragmatic pleurodynia. There have been many epidemics in the Scandinavian countries, Iceland, and Finland and some in England. The exact pathology is unknown because there have been no autopsies.

The disease is at times mainly seen in childhood, but adults are not immune as the outbreak reported by Locke and Farnsworth among college students clearly shows. As its various names indicate it is presumably a disease of the diaphragm or of the pleura covering its thoracic surface, though it is only occasionally that a pleural friction rub can be demonstrated.

In epidemics the explosive character of the onset with intense pain and fever, especially in children, is alarming. While the pain is usually at the level of the attachment of the diaphragm and is associated with the respiratory function and aggravated by sneezing, coughing, exercise, laughing and deep breathing, there are cases where the distress is mainly abdominal and in case of erroneous diagnosis may lead to unnecessary surgery. There may be tenderness over the painful areas, which may even involve the lumbar region, shoulders and the neck. Cutaneous hyperesthesia and muscle rigidity may be present. Fever may be high at the onset of the disease, may reach $F 104^{\circ}$ or even $F 105^{\circ}$, but usually drops in 24 to 48 hours. The breathing is shallow and the patient often lies in a position which will minimize movement of the affected parts. In children nausea and vomiting may be striking initial symptoms with severe diarrhea and distention. Both Locke and Nichamin have called attention to the frequency of relapses during the original attack, and

the latter has emphasized that recurrent attacks may occur from 2 to 30 months after the original one. Practitioners, especially those living in regions where the Cocksackie virus has been shown to be present, should be on the lookout for this disease.

G. B.

Stamford Medical Society Honors 50 Year Members

James J. Costanzo, Charles L. Dichter and Jacob Nemoitin, members of the Stamford Medical Society who have seen fifty years of medical service, were honored by a dinner at the Half-Way House in June. About 110 physicians attended. J. Howard Staub, previously honored for fifty years of practice, was the toastmaster.

The unusual feature of the dinner was the fact that the sons of the three physicians thus honored, two of them physicians themselves, gave brief accounts of the life histories of their fathers. Inscribed gifts were presented to the three fifty year practitioners.

Folsom for Hobby

The appointment of Marion Folsom to be Secretary of Health Education and Welfare is singular, not only because he has never been politically active but he possesses better than a journeyman's knowledge of health, education and welfare. He helped organize Genesee Valley Medical Care (Blue Shield) and is a director of Rochester General Hospital. He is a Harvard College overseer and a trustee of University of Rochester. He served on the advisory council that participated in drafting of original Social Security Act in 1934 and he has been president of his home city's Council of Social Agencies and a director of its Community Chest.

During his 39 year career with Eastman Kodak Co., his efforts in support of employee health and welfare benefits brought down more than once the charge of "socializer" and "welfare stater" upon his head. This notwithstanding his numerous banking directorships and trusteeships. He is on the record in favor of extending social security coverage to more professional people, including doctors. His build is small but his skin is thick and he will stick to his guns.

From Washington Report on the Medical Sciences

*Jour. Amer. Med. Assn. 1952, 148, 1002

†Abstract in Jour. Amer. Med. Assn. 1952, 149, 520

PROGRESS IN CLINICAL MEDICINE

VERBATIM RECORDING

WILLIAM KAUFMAN, M.D., *Bridgeport*

THE MEDICAL HISTORY AND VERBAL THERAPY

Conversations between a doctor and patient are an important source of clinical information, and often have therapeutic value as well.⁵ The evanescent nature of the spoken word is such that once the interview is over, all that remains in evidence are the memories and written notes which doctor or patient may retain. But neither memories nor notes may reflect accurately what transpired during the interview.

The usual case history³ based on a doctor's notes and impressions is edited and slanted; it is subject to grave semantic errors; to mistakes of omission and commission; to unconscious substitution of the doctor's beliefs and interpretations for facts related by the patient; and to distortions arising from quotation of the patient's statements out of context. Although the conventional case history complies with legal necessities of record keeping in office or hospital, and has the advantage of conserving time, it may obstruct rather than facilitate the most efficient solution of a patient's pressing health problems.

Today, with the aid of any one of many different electronic recording devices, doctor-patient interviews can be recorded and later played back or transcribed, giving the doctor an opportunity to evaluate verbal data more objectively than otherwise possible. He can study not only the patient's verbal behavior, but also his own. This method is time consuming, but rewarding. A series of recordings can become a living biography of a patient's health and illness over a period of years. A doctor can get the most out of every interview with a patient by becoming more aware of the meaning of pertinent data elicited. The patient, of course, is always telling more about himself than the doctor can absorb during any given interview. I have found that some matters which at the moment of utterance seem irrelevant, prove in time to be the most important clues to the core of a patient's health problems.^{2,4}

In taking a medical history in the conventional

The Author. *President, American Academy of Psychosomatic Medicine*

SUMMARY

Verbatim recording of patient-doctor interviews can help a physician to improve his techniques in the verbal management of patients. Many electronic devices available today make it a simple matter to record the verbal interchange between patient and doctor. Study of such recordings at leisure allows the doctor to extract the greatest amount of useful clinical information from each conversation with his patient. In addition, by listening to the playback the physician may gain insight into the part he plays in making his professional relations with his patient a success or failure.

With increased self understanding and more efficient interpersonal communication stemming from the proper use of verbatim recording, a doctor can become a more objective, effective and relaxed practitioner of medicine. Furthermore, verbatim recording may make available, for future use, facts of medico-legal or research value.

In the field of medical education, verbatim recording can help improve methods of teaching medical students, interns, residents, and even practicing physicians.

The special problems in medical ethics created by verbatim recording may be solved easily by following certain simple formulations cited in this paper.

way, a doctor is handicapped, because he must simultaneously listen, speak, take notes, try to establish and maintain good rapport and not betray certain emotions which he may feel. He must talk as an active participant, plan his next questions as well as the strategy of his entire examination, parry any undesired questions without offending the patient, all this while searching for clues to the correct diagnosis and planning short and long term clinical

investigation and therapy. He must guard himself against making statements which might have a destructive effect on the patient's morale. Besides this, he must not be distracted by thoughts about other patients who are acutely ill, and he must not think of any of his own personal problems. All this to be done within a given time schedule!

But with the use of verbatim recording, the doctor can listen to recordings of interviews at his convenience, without the pressures and distractions involved in being an active participant. This makes it easier to review the verbal information and arrive at an objective interpretation. Not everything a patient says is important. But many important data which are not properly evaluated or even sensed, at the time of the interview, can be discovered in the playback, and a correct estimate of their importance can be made. The doctor may find also that at times he did not elicit pertinent information because he neglected to explore certain aspects of the patient's health problems. By reviewing recordings of successive interviews, discrepancies in the patient's story may become apparent, and the doctor can later try to clarify these points.

Analysis of verbatim recordings of his interviews with patients permits the physician to see his own defects and to correct them. He can hear himself as others hear him. The recordings may show that he mumbles, that he does not talk loud enough, that he stutters and stammers, clears his throat in an irritating way, or "uhs" frequently, or uses clichés and stale jokes. He may recognize that without meaning to he sounds anxious, impatient, gruff, angry, sad or depressed. He may find himself rudely interrupting without reason or cutting off a patient who tries to talk about emotional problems. He may make conversational digressions which only annoy the patient. The physician may realize that he asks leading questions to elicit the answers he wants, rather than questions which a patient could answer correctly. This is particularly true when he forces a patient to give a "chief complaint," and thus many "chief complaints" written in case histories are artifacts.

The doctor may also learn that he reacts not only to the words his patient uses, but also to the accompanying emotional colorations of anxiety, anger, rage, despair.¹¹ By understanding the contagiousness of the emotional aspects of interpersonal communication, he can then react intellectually to the patient's talk without becoming personally involved

in undesirable emotional ways. With this mastery, he need no longer dread the neurotic or hysterical patient. He can permit the patient to display intensely emotional verbal behavior, while he himself consistently and calmly follows the course necessary to get the facts he must have before he can suggest appropriate therapy.

A specialized use of verbatim recording is the analysis of the speech habits of individuals suffering from different types of psychiatric illnesses. With more studies of this kind, we may some day attain a better understanding of mentation in these disorders.⁷

Playback of recordings has been used by some physicians^{8,9} to help a patient gain insight into his emotional problems. The doctor allows the patient to listen to the recording and then points out the meaning of the patient's verbal reactions in response to certain verbal cues introduced by the examiner. In some instances this may shorten the time required for psychotherapy.

I have used this technique successfully in the treatment of couples having marital problems. I permit them to talk in my office about their mutual problems, and they often forget my presence and say what they feel. Then each one separately is allowed to listen to the tape recording which I interpret to help them gain insight. Then we all listen to the playback together. This procedure helps to define the irrational aspects of the problem, helps to establish the true nature of their differences and aids in the final solution of their mutual problems. "It's like hearing strangers talk and you feel so terrible about the silly things you hear yourself say."

Verbatim recordings of interviews and telephone conversations may be of medicolegal value, particularly where the courts have to decide which of two allegations, that of patient or doctor, is likely to be correct.¹⁰

With the use of verbatim recording, a doctor can become a more perceptive, relaxed and effective practitioner of the art and science of medicine, and as an indirect consequence he may learn to manage his own emotional life better. He will be in a position to render better medical service than would otherwise be possible, because no matter what else he treats, he will treat a patient's emotional and psychological disorders as part of total medical care. He will know how to establish effective two-way com-

munication between himself and his patient; the essence of good medical practice.

RECORDING MACHINES

Any doctor wishing to use the technique of verbatim recording in his practice should be careful to select that particular device which meets his special needs. Available machines include portable and non portable tape, wire, plastic band or disc recorders. No machine should be purchased on the basis of a sales talk, promises, or a limited trial. Unscrupulous salesmen often misrepresent their product. Any contractual relations should be in writing and the doctor should understand what the company agrees to give him in return for his money.

My own preference is for the tape-recording machines.* The quality of the recordings is excellent, and if after the material is transcribed I have no further need for the original recording I can use the magnetized tape anew to record other interviews.

Tape-recording machines permitting continuous recording for one or two hours without changing the reel are more convenient than those running for shorter periods of time. The cost per hour of recording is sufficiently great to make it expensive to build up a large tape-recording library of clinical verbatim records. I find it less expensive and more convenient to use a standard dictating machine for rerecording tape material that I want to file for future use.

With a suitable preamplifier, many of the dictating machines now available can be successfully used for verbatim recording.

ETHICS

It is entirely improper to use recordings of patient-doctor interviews for the entertainment of colleagues, friends and family. This is as much a breach of ethics as any other improper disclosure of confidential communications between patient and doctor.

The communications of a patient to his doctor are to be regarded as privileged, excepting under specified circumstances defined by law.¹⁰ Anything the patient says, the doctor can remember or make notes of, with all this information intended to be used eventually for the benefit of the patient. The recording of patient-doctor interviews is merely an extension of note taking, using an electronic method which allows no words to escape.

I believe that a doctor is privileged to make such recordings provided he does not use these without the patient's consent before scientific meetings or for teaching purposes and provided the person cannot be easily identified and publicly embarrassed. Even if the patient gives permission for use of the material, I think it is wise to edit out the patient's identity.

I believe that by consulting a physician, a patient implicitly consents that any verbal material he gives the doctor can be used by the doctor in any way which will be advantageous to the patient in terms of better diagnosis and medical treatment. For this reason, I have no hesitation in asking a consultant to listen to verbatim recordings if this seems to offer help in arriving at a diagnosis or suggesting solution of health problems.

Many patients have no inhibitions when their conversation is being recorded during consultations. In fact, they enjoy it, and miss it when it is not done. Others have temporary concern about the procedure, and tend to look at the microphone uneasily, but usually they become accustomed to it.

Some patients are never able to speak freely when they know their words are being recorded. In such instances it may be necessary to make such recordings without the patient's knowledge.

MEDICAL EDUCATION

Verbatim recording can be incorporated into the routine teaching programs of medical schools, for intern and resident instruction, and for postgraduate medical education.

By using recordings of student-patient interviews, medical students might learn how to improve their methods of interrogating patients. Instructors might learn what special points need emphasis in the teaching program. This would result in an overall increase in the efficiency of medical education, and there would be no need for the student to have to wait until his intern or resident years to gain skills which he should have been taught in medical school.

Many hospitals today are faced with the serious problem of providing their house staffs with continuous postgraduate education. Economic considerations may prevent the employment of a full-time director of medical education, and members of the hospital staff may be reluctant to assume the burden of giving formal lectures.

Tape recordings of lectures prepared especially for intern and resident education by outstanding

medical school teachers might be lent or rented to hospitals for this purpose. The AMA might set up minimal standards for the amount and variety of tape-recorded didactic material which would satisfy the educational requirements for interns and residents. These recorded lectures could be revised yearly, and in this way the postgraduate course for the house staff would be kept up to date. Of course, this would not be a substitute for clinical demonstrations, but colored movies and slides might supply enough material to substitute partially for clinical demonstrations.

Because many persons find it easier to remember what they hear rather than what they read, lectures have an important role in the postgraduate medical education of the practicing doctor. Aside from reading various informative medical books and journals, a doctor's continuing education is obtained by attending lectures, medical society meetings and taking formal courses.[†]

Usually at medical meetings it is difficult to take adequate notes summarizing the lecture material for future reference. Sometimes several talks are in progress simultaneously, and a doctor wanting to hear more than one must be disappointed. If verbatim recordings of these talks were available on a loan or rental basis, they might be used to increase his knowledge without needing to wait months or years until the talks were published in medical journals. Of course, speakers at medical meetings should give consent before their talks are recorded; and any speaker should reserve the right to publish hitherto unpublished material which he might be presenting at the meetings.

Groups of doctors living in a community, including those unable to attend the meetings, might share the expense of such recordings, and derive important benefits. Some postgraduate courses might be taped and sold, rented or lent to doctor-consumers. This might prove especially valuable to physicians living in communities remote from teaching centers. Such lectures would not take the place of clinical demonstrations, but would serve as a vital source of material for postgraduate medical education, available to all.

MEDICAL PUBLIC RELATIONS

Every doctor who speaks before the public should be an ambassador of good will for the entire medical profession. But often he fails in this because he has not taken the trouble to acquaint himself with the rudiments of good public relations, public speaking,

and the principles governing effective mass communication.^{1,6,12} As Dr. W. W. Bauer of the AMA has said: "Ether, when used for the transmission of health education, is not intended as an anesthetic. Nevertheless, if not tuned out first, certain health talks have precisely that effect."¹

Perhaps those participating in medical programs might be helped by detailed study of tape recordings of their public utterances. Such recordings might be reviewed by a group of public relations men and doctors. As a result of such analysis, very quickly constructive principles might be evolved so that doctors would become expert in communicating with the public.

If the medical profession is to have its rightful importance in our society, we must come out from behind our desks and take part in the education of the public about medical matters and the doctor's point of view.

*During the past year, I have found it more practical to record all interviews with patients on a 30-minute Dictaphone (R), using filable plastic belts.

†Since this paper was accepted for publication, The Audio-Digest Foundation, a non-profit subsidiary of The California Medical Association, 800 North Glendale Avenue, Glendale 6, California, has made available on a subscription basis tape-recorded medical lectures and digests of the medical literature.

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THE PRESIDENT'S PAGE

ATTENDING medical meetings is a very good habit for a physician to acquire. About twenty-five years ago, on one of these occasions, as I was descending the broad stairs leading to the Scientific Exhibits, there before me was a large sign which read:

THERE ARE TWO KINDS OF DOCTORS

One who is continually learning

One who is continually forgetting

A few years before this occasion the leaders of your Society recognized the need for a quick refresher course for our members; thus our Clinical Congress came into being. The first meeting was held in September, 1925 at New Haven. Since that time the Connecticut Clinical Congress has been an annual event except for the year 1945.

In 1952 we had our largest attendance, 812. At this time our membership numbered 2,818 and 598, or 21 per cent attended. In 1954 our membership had increased to 3,008, yet only 423, or 15 per cent were present at the Clinical Congress. The quality of our Clinical Congress makes it one of the outstanding medical educational opportunities in the country. Many of us wonder why such a small percentage of our members take advantage of this meeting.

The programs have been designed to meet the "up to date" needs of the practicing physician. Just enough ultra scientific papers are sandwiched in to clarify their clinical significance. Look over the program in this issue and you will see what I mean. After doing so I hope your appetite for "learning" will be so whetted you can't resist the temptation to attend. It is interesting to note that four-fifths of the membership of our society is within one hour's driving time of New Haven.

Oliver L. Stringfield, M.D.

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COUNCIL MEETING

The monthly meeting of the Council was held at the offices of the Society on June 23, 1955. The meeting was called to order by the Chairman at 4:00 P. M. There were present in addition to the Chairman, Dr. Fincke, Drs. Stringfield, Ogden, Couch, Barker, Weld, Murdock, Gibson, Feeney, Marvin, Gallivan, Ursone, Tracy, Russell, Archambault, Ottenheimer, Gens, Clarke, Meyers, Dwyer, Starr, Gilman. Absent: Drs. Danaher, Flaherty and Buckley.

It was voted that Dr. John C. Allen, Hartford, be nominated to the Governor for appointment to the Connecticut State Board of Examiners for Physical Therapists in accordance with Section 1667 c of the Cumulative General Statutes of Connecticut.

It was voted that Albert U. Peacock, Hartford, be appointed a member of the Committee to Study Neonatal Mortality to replace John W. Buckley, resigned.

It was voted that Noah Barysh, New Milford, be appointed to the Committee on Public Health as a representative from Litchfield County to replace Andrew W. Orłowski, resigned.

It was voted that Edward T. Wakeman, New Haven be reappointed to the Committee on Public Health.

It was agreed that consideration be given to the appointment of two physicians to "A Commission to Study the Problem of Hospitalization of the Mentally Ill" if and when such a request is received from the Governor of the State or the Commissioner of Mental Health.

The executive secretary presented a brief report from Carl E. Johnson, chairman of the Special Committee to Study Expansion of the Society's Building and supplemented the report with a statement of events that had taken place since the report was written. It was voted to accept this progress report and the committee be continued to extend its inquiries.

The Chairman of the Council, Dr. Fincke, reported briefly for the Committee to Inquire into the

Creation of a Loan Fund for Interns and Residents and stated that a more detailed report would be given at the next meeting of the Council.

Directives for the standing Committee on Third Party Payments and its relationship to the Special Committee to Study Third Party Payments for Medical and Ancillary Non-Surgical Services were discussed at length and it was agreed that the Chairman of the Committee on Third Party Payments, William H. Curley, Jr., be directed to call a meeting of that committee of which Benjamin V. White, chairman of the Special Committee to Study Third Party Payments for Medical and Ancillary Non-Surgical Services, is a member and in such a meeting define the responsibilities of the Committee on Third Party Payments.

The following proposed changes in the By-Laws relative to Past Presidents being ex officio members of the House of Delegates were approved and it was voted to recommend their adoption to the House of Delegates at the Semi-Annual Meeting in 1955:

It is recommended that Article VIII, Sec. 1 be amended by the addition of a new Par. 2—"All Past Presidents of the Society shall be ex officio members of the House of Delegates without the privilege of voting."

Article VIII, Sec. 1 is amended so that the present Par. 2 becomes Par. 3 and the present Par. 3 becomes Par. 4.

The executive secretary presented a preliminary report of the 1955 Annual Meeting, which disclosed

a surplus of approximately \$2,900, with a few small bills outstanding.

The report of the Special Sub-Committee to consider the amended report of the Committee on Hospitals as approved by the House of Delegates on April 26, 1955 was presented for consideration. (Committee John N. Gallivan, chairman, John P. Gens, H. M. Marvin, Ralph T. Ogden, F. Erwin Tracy.)

The Chairman of the Council read the following excerpts from the amended report of the Hospital Committee approved April 26, and stated that the present discussion would be confined to this part of the report:

"The Hospital Committee recommends that the Connecticut State Medical Society, through proper channels, present all the facts before the present Attorney General and respectfully request that he review the opinion of his predecessor. The committee also recommends that the Attorney General be requested to give an opinion on the following specific questions:

1. Can a nonprofit hospital or other corporation, group or association of laymen be licensed to practice medicine and treat the sick in Connecticut for a fee?

2. Are existing laws relating to the practice of medicine in Connecticut violated if a licensed physician enters into a contract with a nonprofit hospital wherein the physician renders medical services for a salary, and wherein the hospital bills the patient and collects fees for those services for the profit of the hospital?

"If the Attorney General agrees to answer the questions and to review the opinion of his predecessor, the Council shall be directed to confer with the Connecticut Hospital Association, Connecticut Medical Service and Connecticut Hospital Service in an attempt to negotiate a mutually amicable solution and present all pertinent facts to the Attorney General for his consideration."

A majority report was presented by John N. Gallivan and minority reports had been submitted by Dr. Marvin and Dr. Gens.

The Chairman invited Dr. Gallivan to open the discussion on the majority report following which Dr. Marvin was invited to discuss his minority report and Dr. Gens his minority report. Then other members of the committee, Dr. Ogden and Dr. Tracy, were invited to enter the discussion.

The question was raised as to whether the Council

had a direct mandate from the House of Delegates to proceed with the recommendations in the amended report of the Committee on Hospitals and this was discussed at length. Dr. Gallivan presented an observation that the Council was in a sense the Executive Committee of the House of Delegates which was the Board of Directors of the Society and under Robert's Rules of Order, which rules govern the procedures of the Society, the Executive Committee could not set aside an action of the Board of Directors.

All aspects of the subject were discussed at length and Drs. Feeney, Archambault, Ottenheimer, Dwyer, Stringfield and Murdock participated.

It was moved by Dr. Gallivan and seconded by several to accept the Report of the Majority of the Committee and adopt the five recommendations contained therein. It was moved to amend this motion to direct that Recommendation No. 2 in the Report become No. 1, Recommendation No. 3 become No. 2, Recommendation No. 4 become No. 3, Recommendation No. 1 become No. 4 and Recommendation No. 5 be No. 5.

This motion to amend was carried and the report was so amended. The original motion as amended was then put to vote and carried by a divided voice vote with no count.

A motion that the present committee named above be discharged and another appointed was lost and the committee was continued with thanks with direction to function as it elects. It was suggested that the committee be instructed to report to the Council at its October meeting, but this suggestion did not prevail and no time was set for its next report.

It was moved that before executing recommendation No. 4 in the report which has to do with resubmitting the question to the Attorney General for opinion, the matter be again submitted to the House of Delegates for consideration. This motion was lost.

Richard R. Braisted, Hamden, Tufts Medical School Class of 1958, was elected a student member of the society.

The executive secretary presented a report for the Council's Subcommittee on a Pension Plan for Society Employees. This report recommended a change in the basic element of the pension plan. Originally the committee had been authorized to proceed with the development of a retirement plan to be contributed to jointly by the Society and

employees. After thorough and detailed study of the wishes of the employees and certain other factors involved, the committee in this report recommended that a plan excluding contributions by employees be established. Otherwise the recommendations were the same that had been previously discussed in the Council.

It was moved and unanimously voted that the recommendations of this committee be approved and the plan instituted at an early a date as possible.

It was voted to withdraw funds from the accumulated income of the Russell fund for the purchase of new equipment for use in the Society's office and the public relations division in an amount of approximately \$1,200.

On a motion by Dr. Russell, seconded by several, it was unanimously voted that Dr. Joseph A. Fiorito be reappointed to the Committee to Study Neonatal Mortality.

Dr. Marvin, the society's representative on the committee to arrange the Clinical Session of the AMA in Boston November 29 - December 2, 1955, urged members of the Council to seek contributions to scientific papers to be presented at the meeting.

It was agreed that meetings of the Council be omitted during July and August as usual, unless the necessity for a special meeting arose, and that meetings would be resumed in September.

The meeting adjourned at 6:45 P. M.

(Continued on page 682)

THE HISTORIAN'S NOTE BOOK

THE LITCHFIELD COUNTY MEDICAL ASSOCIATION

FRANCIS A. SUTHERLAND, M.D., *Torrington*

THE Litchfield County Medical Association has been a leader in medical organization affairs for nearly 200 years and has been a subject for much exciting study. The late Walter Steiner of Hartford concluded that the Litchfield County Medical Association was organized on July 5, 1779. But there will always be in the background of this investigation the statement of Judge Samuel Church at the Litchfield County Centennial in 1851 that a medical society was formed in the county as early as January 1767. Where Judge Church obtained his information, or how reliable it is, remains to be determined. It is probable that he referred to a meeting of physicians held in Sharon in that year, from which grew a loose transient organization with the high-sounding name of the Medical Society of the United States of America. It is interesting to conjecture that this is perhaps the first time the term "United States of America" was used. The State Society was chartered by the Connecticut General Assembly in May 1792, and in what is believed to be the first private charter granted by the Assembly. This county was represented at the first meeting of the State Medical

Society on October 9, 1792 by Seth Bird, Samuel Orton, Samuel Woodward, Seth Hastings, Samuel Rockwell, and by the annual meeting in 1793, fifty-one physicians of Litchfield County were members of the State Society.

During the years since 1792 our Association has provided nine State presidents. The first was William Buell, Litchfield 1832, followed by Luther Ticknor, Salisbury 1843, Josiah G. Beckwith, Litchfield 1861, Henry W. Buell, Litchfield 1872, William Deming, Litchfield 1881, Edward H. Welch, West Winsted 1905, Elias Pratt, Torrington 1923, Charles H. Turkington, Litchfield 1937, and Thomas J. Danaher, Torrington 1950.

Although the physicians from this county who have engaged in State Medical Society affairs are not numerous, they have been important and active people. Many of the substantial accomplishments of the State Society have been proposed or furthered by them. For a small county group, this association has played an important part in medical organization developments.

From address by retiring president delivered at 191st annual meeting, April 19, 1955

Special Article

SENATE JOINT RESOLUTION NO. 1 (The Bricker Amendment)

D. OLAN MEEKER, M.D., *Riverside*

The Author. *Chairman, Committee on National Legislation, Connecticut State Medical Society*

THE letter of Dr. Goodrich, Jr.,* points up an unusual fact. Americans are granted as being the best informed people in the world about things that concern them; yet fewer Americans know about Senate Joint Resolution No. 1 than any other important issue of our time.

This proposed Constitutional amendment would prevent treaties similar to the United Nations Charter from overriding the laws of this country; it would prevent any President from bypassing Congress by making "executive agreements" with other nations—agreements which have the same effect as treaties cancelling any and all of our Federal or State laws in conflict with them.

Article VI of the Constitution is the provision to which the proposed amendment is primarily directed. It provides that: "This Constitution, and the Laws of the United States which shall be made in pursuance thereof; and all Treaties made, or which shall be made under the Authority of the United States, shall be the supreme law of the land; and the Judges in every State shall be bound thereby, anything in the Constitution or Laws of any State to the contrary notwithstanding."

The Constitution thus makes laws of Congress the supreme law of the land only when made in pursuance of the Constitution, while treaties are the supreme law of the land when made under authority of the United States, but without the requirement that they be pursuant to the Constitution.

Article VI of the Constitution was the first instance of any government declaring that treaties are to be the supreme law of the land. With a few minor exceptions other governments have not followed the example. It is not a requirement of international

law that treaties be enforceable as municipal law in the courts of the contracting parties. The United States at present is wide open for the intrusion of alien philosophies via the treaty route.

You might ask what some of the treaties proposed by the United Nations would do to us if they were approved by the Senate.

There are today in existence, enacted or proposed, over 200 treaties which seek to regulate this nation's internal domestic affairs.

Here is a brief list of the more important ones:

1. An international law under which Government would give people money for having babies, sickness, "a morbid condition, whatever its cause," "inability to engage in any gainful activity," and death itself. This law includes a full-fledged program of socialized medicine, with patients allocated to doctors and hospitals under Government direction. The taxes required to support it would break any free economy.
2. An international law under which a citizen could be tried, in a domestic or an international court, for genocide (race killing) or complicity in genocide. This law makes it a criminal act to "cause mental harm" to members of a racial or religious group. Under this law an American might be tried and put in jail for venturing to criticize the Hindus or the Hottentots.
3. An international law under which an American citizen could be brought to trial before an International Criminal Court for criticizing foreign governments or their officials. Trial would be without jury and without right of appeal.
4. An international recommendation to empower Government to force men and management, in an industry, into nationwide bargaining, and to "negotiate, conclude, revise and renew" collective bargaining agreements. This would mean Government

*See Letters to the Editor, page 691.

takeover of collective bargaining and determination of wages by Government decree.

5. An international law abridging freedom of religion, freedom of speech, and the right of peaceable assembly, thereby in effect superseding Article I of our Bill of Rights, which prescribes that "Congress shall make no law respecting an establishment of religion . . . or abridging the freedom of speech or of the press; or the right of the people peaceably to assemble." The proposed international law states:

Freedom to manifest one's religion or beliefs may be subject to "such limitations as are prescribed by law."

Freedom of expression may be subject to "certain restrictions, but these shall be such only as are provided by law."

No restrictions shall be placed on the right of peaceable assembly "other than those imposed in conformity with the law."

You will say to yourself, "This is impossible—what are the chances that treaties of this sort might become law in the United States?"

Let us take a quick look at the present method of treaty ratification.

Under our Constitution, treaties are submitted to the Senate only. The House of Representatives does not vote on a treaty, even though its terms may deal with internal domestic law.

A treaty can be ratified by a two-thirds vote of the members of the Senate present and voting on the day the vote is taken. Unless the question of a "quorum" is raised, a treaty could be ratified by a mere handful of Senators. This has actually happened.

There is growing international pressure upon the United States to ratify treaties enacted by the United Nations and its agencies. Most other countries do not understand our philosophy of freedom, and have never known liberty as we know it here. Their idea of the way to get anything done is to have government do it. And they sincerely do not see why we should not do it their way.

Many people are worried about this situation. They are afraid that on the ground of "maintaining pleasant international relationships," and with the urging of Socialist-minded political groups here at home, the Senate, by a two-thirds vote of those present, might some day ratify treaties which would curtail or destroy some of our basic liberties. They

believe that the Constitution should be amended to provide a greater safeguard for the preservation of our way of life. They believe that the House of Representatives, as well as the Senate, should have a voice in any matters affecting internal domestic law.

Summed up, the treaty problems with which the Bricker-American Bar Association Amendment is concerned are (A) the treaty supremacy clause in our Constitution, and (B) the method whereby the terms of a treaty or other international agreement become effective as internal domestic law in the United States. Now let's consider the text of the Amendment.

The Bricker-American Bar Association Amendment provides, first, that a provision of a treaty or other international agreement which conflicts with the Constitution shall not be the supreme law of the land nor be of any force or effect.

This provision would limit the treaty supremacy clause in our Constitution. It would mean that a treaty could not override the Constitution—the Constitution would override the treaty.

The second paragraph of the pending Bricker Amendment provides that a treaty or other international agreement shall become effective as internal law in the United States only through legislation valid in the absence of international agreement.

Legislation valid in the absence of international agreement simply means laws, in line with the Constitution, passed, like other laws, by both the Senate and the House of Representatives.

This provision would not affect treaties or international agreements dealing with external affairs. The Senate could go right on ratifying treaties having to do with matters such as commerce, navigation, peace and friendship between nations, mutual defense, etc. Senate ratification of a treaty dealing with internal law, however, would mean only that its provisions would be put up to both the House and the Senate, like any other law, for adoption or rejection.

For example, the Senate might ratify a United Nations' treaty providing for socialized medicine, but as far as the United States is concerned this would only serve to bring the matter before both the House and the Senate, and socialized medicine would not become law in this country unless both the House and the Senate enacted legislation putting it into effect.

Other nations would understand this. In fact, this

is the way it is done with treaties affecting internal law in most other countries today. In this connection Judge Florence E. Allen, Judge of the United States Court of Appeals for the 6th Circuit, says in her book entitled "The Treaty as an Instrument of Legislation:"

"It is the rule in all but a very few other countries generally that treaties take effect as municipal or domestic law only when implemented by legislation enacted by the full legislature. This safeguard does not exist for the United States."

The proposed Amendment would provide this safeguard.

The third paragraph of the proposed Amendment assures that a treaty could no longer be ratified by a mere handful of Senators. It says that "the vote shall be determined by yeas and nays, and the names of the persons voting for and against shall be entered on the Journal of the Senate." If such a record vote discloses that less than a quorum (49 Senators) are present, the vote is null and void.

The arguments against the Amendment fall into four main groups. They are:

First: Opponents of the Amendment present the argument that although our Constitution says that treaties "shall be the supreme law of the land," the Constitution really does not mean what it says. They say that "of course treaties which conflict with the Constitution would be declared null and void," and they cite a number of early court cases in which this contention has been upheld. Recent court cases, however, indicate a reversal of that view.

The courts, including the Supreme Court itself, have over the years disagreed on the question of treaty supremacy. The proponents of the Amendment say, however, that leading authorities on constitutional law express no doubts on this score. They point out that the Committee on Peace and Law of the American Bar Association is of the opinion that treaties can override the Constitution, and that according to Judge Allen, from whom we have previously quoted, "Under the Constitution of the United States a treaty, when fully executed and in force, is the supreme law of the land."

Second: Opponents of the Amendment say that even if treaties are the supreme law of the land, there is nothing to be alarmed about because no treaty contrary to the United States Constitution, or abridging the freedoms and liberties of American citizens, would be ratified by the Senate.

Proponents of the Amendment agree that this is no doubt true as of today—but what about tomorrow? Who knows what pressure might be brought to bear, or in what direction the political wheel might turn? They urge the passage of the Amendment as a safeguard for future generations.

Third: Opponents of the Amendment say that giving Congress the power to regulate international agreements, insofar as they relate to internal domestic law, would "tie the hands of the President" and make it "difficult for the State Department to function."

In voicing this objection they have in mind the type of international agreement known as an "executive agreement." This is a formal arrangement with another nation concluded, insofar as the United States is concerned, merely by the signature of the President, or that of the Secretary of State, as his agent.

They say that the number of "executive agreements" concluded in the course of a year, primarily in connection with national defense and other matters of international concern, run into the thousands; and that the foreign relations business of the Government simply could not be conducted if all of these agreements had to be submitted to the Congress for approval.

On this latter point the proponents of the Amendments explain that it is not the intent of the Amendment that Congress shall pass on all executive agreements. The Amendment would apply only to executive agreements the terms of which might affect internal domestic law in the United States. The President could go right on making executive agreements as he does now, so long as they did not attempt to change our internal law.

For example, an executive agreement with Canada setting up a station for weather study in the Arctic would certainly not require review and approval by Congress. But Congress should certainly be consulted concerning an executive agreement which might threaten to limit the freedom of the press; or one which promised another nation that, if attacked, the United States would go to war in its defense.

In this latter connection it is pointed out that the Supreme Court has ruled that an executive agreement is, like a treaty, the supreme law of the land. Furthermore, as things stand now, it is apparently up to the President himself, and the President alone, to decide whether an understanding arrived at with

a foreign nation is an "executive agreement," or a treaty requiring Senate ratification. At present an executive agreement may, but is not required to, be approved by the Congress. A President, under his "executive agreement" powers, could commit this country to any course of action he chose. As Senator Bricker said, a President "could use such powers to become an absolute dictator in both foreign and domestic affairs."

It is the purpose of the Amendment to subject any "executive" or other international agreements affecting the laws under which we live, inside the United States, to congressional regulation. The idea is simply that our own Senate and our own House of Representatives should always have their say as to our own laws in our own country.

It was an "executive" agreement which was made at Yalta—an agreement which was a monstrous betrayal of the American people. As a result of that agreement we have spent \$290 billions on military affairs and \$50 billions on foreign aid. The following countries were handed to Stalin: Albania, part of Austria, Bulgaria, Czechoslovakia, Estonia, East Germany, Hungary, Latvia, Lithuania, Poland, Rumania and Yugoslavia in Europe. In Asia Stalin got the Kurile Islands, Manchuria, Mongolia, North Korea, Sinkiang and half of Sakhalin. As a result of the Yalta Agreement the Republic of China and part of Indo-China became Soviet property. Stalin had delivered into his hands 600,000,000 people by an "executive" agreement.

Fourth: The final argument of the opponents of the Amendment is simply that we have gotten along very well thus far with the Constitution as it is—so why change it? To this, proponents of the Amendment reply: "Changing the Constitution is just what we are afraid of. We do not want the Constitution changed by treaties. We want the Constitution to be supreme over treaties. We do not think the framers of the Constitution ever intended to let our Bill of Rights and our basic liberties be threatened by Treaty law."

The last session of the Senate failed to pass the Bricker Amendment by one vote—there were 60 in favor and 31 against—a two-thirds vote being required.

It is time that the people of the United States do something about this resolution. Their future is at stake. Advise your Senators how you feel. We are in danger of losing our independence to the United Nations or other global groups.

Secretary's Office (Concluded)

Council Meeting

A special meeting of the Council was called by the Chairman, Dr. Fincke, on July 6, 1955. Dr. Fincke being unavoidably detained from the meeting had asked Dr. Cole B. Gibson, speaker of the House, to preside in his stead. Dr. Gibson waited until 5:20 P. M. and then announced that a quorum was not present as provided under Article IX, Section 2, Par. 1 of the By-Laws of the Society, and that a formal meeting could not be held. There were present in addition to Dr. Gibson, Drs. Stringfield, Barker, Weld, Gallivan, Tracy, Russell, Buckley, Dwyer. Absent: Drs. Ogden, Couch, Danaher, Murdock, Feeney, Marvin, Fincke, Ursone, Archambault, Flaherty, Ottenheimer, Gens, Clarke, Meyers, Starr and Gilman.

The deficiency in the quorum was due to the fact that there were Councilors or Alternate Councilors present from but from three counties, the By-Law requirement for a quorum is Councilor or Alternate Councilor representation from four counties.

The purpose for which this meeting was called was to review and act upon recommendations passed by the Committee on Public Health at a special meeting held on June 30. These recommendations relating to answers to four questions concerning the use of poliomyelitis vaccine had been directed to the Society by the Poliomyelitis Vaccine Advisory Committee of Connecticut for consideration prior to a stated meeting of that committee to be held on July 11, 1955.

There was general informal discussion of proper procedure in the absence of a quorum and it was finally agreed that Dr. Stringfield, who was present and who is also the Chairman of the Poliomyelitis Vaccine Advisory Committee, should explain the circumstances to that Committee at its meeting on July 11, 1955.

The discussion closed at 5:45 P. M.

Meetings Held During July

- July 6—Conference Committee with Connecticut Bar Association
- July 12—Connecticut Medical Examining Board
- July 13—Connecticut Medical Examining Board
- July 14—Connecticut Medical Examining Board
- July 14—Committee on Third Party Payments
- July 20—Subcommittee on School Health
- July 28—Connecticut Medical Examining Board

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Today's Health, popular and authentic health magazine published by the American Medical Association has one objective—sound health education. Its pages help to offset the rumors and half truths which often mislead people.

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New TV Health Education Series Started

A new thirteen-week series of health education telecasts has been started under sponsorship of the Connecticut TV Committee for Health Education.

Titled "Accent on Living," the series is presented as a public service from the studios of WKNB-TV, New Britain, each Thursday, 2:45 to 3:00 P. M.

Each of the statewide health agencies represented by the TV Committee assists in producing the programs, and moderator for the series is Robert Wakeley, New Haven, representing the Connecticut Division, American Cancer Society. Other committee members represent the Connecticut State Department of Health, the Connecticut State Medical Society, 12 statewide voluntary health agencies and four television stations.

The first program, July 7, was devoted to recreational facilities in Connecticut, and subsequent programs will present health problems of the summer months.

These will range from sunburn, food poisoning and allergies to swimming and water safety, camping and preschool health examinations. Other programs will deal with rheumatic fever, how to visit hospital patients, cancer examinations, and the value of blood banks in saving lives.

Emergency Call Plan Exhibit in Hartford Bank Lobby

The Society's community service exhibit depicting the growth of emergency call plans was recently displayed under sponsorship of the Hartford County Medical Association in the lobby of the First National Bank and Trust Company, Hartford. The exhibit portrays the growth of emergency plans sponsored by county and local medical societies in Connecticut. The exhibit is designed for hospital lobbies, public libraries, and other buildings, and lobbies of banks, hotels and other commercial buildings. Seven feet in height and nine feet in width, the

exhibit is illuminated and contains a relief map showing locations of the major emergency plans accompanied by the telephone number used by each plan.

Located in the major population centers of the State, the emergency services offered by the plans are now available to eighty per cent of the State's population without toll charge.

The complete story of the plans and how they may be used is told in leaflets which accompany the exhibit. It is available for use by community or local medical associations.

AMA Public Relations Institute To Be Held in Chicago

The American Medical Association's annual seminar in public relations will be held in Chicago, August 31 and September 1, it was recently announced.

The organization of the meeting will follow that of previous institutes, utilizing informal sessions to demonstrate techniques being used throughout the country to help solve relationship problems of State and local medical associations. The institute will be attended by chairmen of public relations committees and medical association staff members.

New Office Plaque Available

New office plaques are now available to physicians through the offices of the State Medical Society. Previously supplied directly from the American Medical Association, the plaques are suitable for desk or wall display in physicians offices and may be obtained at a charge of one dollar each.

The plaque measures approximately eleven by seven and one-half inches and has a laminated buff plastic finish with dark brown lettering. It carries the salutation, "TO ALL MY PATIENTS," and the following statement in attractive lettering:

"I invite you to discuss frankly with me any

questions regarding my services or my fees. The best medical service is based on a friendly, mutual understanding between doctor and patient."

Medical Films Continue In Popularity

During the month of May, two medical association films were shown before three high school audiences and employee groups.

The films, "Your Doctor," and "Operation Herbert," were produced by RKO-Radio Pictures in cooperation with the American Medical Association and are available through the offices of the State Medical Society for showing before community groups.

AMA Distributes Educational Material to Local Groups

An attractive kit of publications prepared to aid the planning of programs by local chapters of the General Federation of Women's Clubs was recently produced by the American Medical Association.

The kit was distributed to almost 2,000 women from all sections of the United States during the recent annual meeting of the Federation in Philadelphia. When presented with the material, each group chairman was advised to contact their State or county medical society to secure physician speakers or when planning other health programs.

Distribution of the material is part of the national program to demonstrate how local medical societies can combine health education and community service in working with other local groups.

New Manual for Medical Assistants

A new 500 page training manual designed to be especially helpful to medical assistants is scheduled for publication next January.

"The Office Assistant—in Medical or Dental Practice" is the tentative title of this new publication. It is being written by Carol Towner of the AMA Public Relations Department, and Portia Frederick, Long Beach, California, instructor of a two-year course for physicians' aides and laboratory technicians.

The manual will be illustrated, and it is planned to devote equal space to actual medical and dental assisting duties and to office procedures. A recent announcement concerning the publication points out that approximately 65 per cent of the physicians in the United States employ only one girl, while another 23 per cent employ two aides. The authors

of the manual will, therefore, endeavor to be instructive in both medical assisting and secretarial duties.

Legislative Discussion Features Connecticut Health League Meeting

Approximately 100 members of the Connecticut Health League attended a panel discussion of health legislation featuring the semiannual meeting of the organization June 22 in the auditorium of the Connecticut Light and Power Company in Berlin.

Fred S. Schuckman, budget director of the State Department of Finance and Control, was moderator for the discussion. Participants were:

Harold Barrett, M.D., Deputy Commissioner, Connecticut State Department of Health.

John J. Blasko, M.D., Commissioner, Connecticut State Department of Mental Health.

Raymond J. Fay, Connecticut State Department of Education.

Rt. Rev. Monsignor John J. Hayes, member of the Connecticut Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm.

Udell LaVictoire, Chief, Bureau of Social Services, Connecticut State Department of Welfare.

Honorable W. Duane Lockard, State Senator, New London, Connecticut.

Paul S. Phelps, M.D., Director, Connecticut State Tuberculosis Commission.

11,546 Physicians at Atlantic City Meeting

A breakdown of registrations at the recent AMA session in Atlantic City shows that a total of 11,546 physicians registered at the meeting.

By States, Pennsylvania had the highest number of registrations, 2,494; followed by New York with 2,054; New Jersey, 1,745, and Ohio, 414.

In a breakdown of the figures, in addition to physicians, there were 15,912 guest registrations, 2,504 exhibitors, and 1,095 guests of exhibitors for a grand total registration of 31,057.

Physicians registered from other countries totaled 237. The best representation was from Canada with 63. The registrations from Cuba numbered 19; England, 14, Philippine Islands, 10, and India, nine. Four of the registered physicians were from Africa; five from Australia; six from Brazil; four from France; seven from Germany, and one each from Portugal, Scotland, Iceland, and Yugoslavia.

NEWS FROM WASHINGTON

Doctor Draft Act Extended Two Years

Both Congressional houses have passed and the President has signed a bill extending the Doctor Draft act for two more years. The Senate vote was unanimous and the vote in the House showed only a handful opposed. President Eisenhower signed the bill June 30, a few hours before both regular and doctor draft acts were due to expire. Two changes are made by the law extending the act. It no longer applies to men over 46 years of age, nor to those 35 and over who at any time have been rejected for a military commission as a physician or dentist in one of the Armed Forces solely on the grounds of their physical condition. On these two points the law now reads: "No person in the medical, dental, and allied specialist categories shall be inducted under the provisions of this subsection: (A) after he has attained the thirty-fifth anniversary of the date of his birth, if he applies or has applied for a commission in one of the Armed Forces in any of such categories and is or has been rejected for such commission on the sole grounds of a physical disqualification, or (B) after he has attained the forty-sixth anniversary of the date of his birth."

Legal interpretations will be needed for the amended law's proviso exempting physicians over 35 years whose applications for commissions have been rejected on grounds of physical disability. However, lowering the age ceiling from 51 to 46 protects from induction every registrant reaching his 46th birthday.

Defense Department points out that the man has to be able to demonstrate that he actually applied for a medical or dental commission and was rejected; a 4-F draft board classification is not sufficient. The department also said that the law will not result in the discharge of men already in uniform, even though they could not be inducted under the new law.

Congressional extension of doctor draft law for two more years is a climactic development but hardly a solution to armed forces' personnel dilemma. Even with this instrument of compulsion at their command, the military medical departments are having to reduce services to dependents and take

precautions against lowering of standards in care of active duty personnel. Army Adjutant General has issued an order to all continental commands explaining the seriousness of the situation and calling for reduction of services to dependents. In compliance, the Military District of Washington already has put out an order all but abolishing medical care for dependents, with exception of obstetrics and pediatrics. Other Army commands undoubtedly will follow suit, or have done so. Army's plight is more serious than sister services because its over-all strength is being reduced sharply and proportionately fewer medical officers will be available for clinical duties, since the numbers assigned to administrative, research and other nonpatient care posts are presently at or near the irreducible.

To meet the crisis, Army commanders are counseled by Adjutant General to screen rigidly the eligibility of dependents for medical care; hire civilian physicians to fullest extent possible; inform servicemen of the shortage of medical personnel so that unnecessary demands for care of dependents may be minimized.

New Legislation on Salk Vaccine

HR6286, HR6287—Free Salk Vaccine Distribution to Needy Children. (Priest and Wolverton.) The American Medical Association on June 28 informed Chairman Priest of the House of Interstate and Foreign Commerce Committee that in its opinion the only Salk vaccine legislation that might be needed would be appropriation of funds to purchase vaccine for needy children, the proposal embodied in these two bills. The Association's views were presented to the committee in a letter by Dr. George F. Lull, secretary and general manager of AMA. He added: "We are convinced that more ambitious proposals which have been advanced are completely unnecessary and will, if enacted, result in an unreasonable expenditure of federal funds and the possible impairment of State, local and voluntary programs which are already established or which are now being formulated." Under other pending bills, the U. S. would supply free vaccine for all children and would take over control of allocation.

Mr. Priest said he hopes this bill will meet the objections raised "both against the limited proposals sponsored by the administration and against the 'all out' program urged by others." The bill's main provisions: (a) A grant to States taking into account 25 per cent of the number of unvaccinated eligible persons, the vaccine's cost and the State's relative per capita income; (b) matching (50-50) grants for additional vaccine to be used by public or non-profit organizations, and (c) additional varying grants to cover administrative expenses of public agencies. Mr. Priest points out that this bill leaves the States free to select methods for inoculations; they will decide what groups among the eligible (under 20 years, expectant mothers) are to receive special consideration. It prohibits means tests in programs conducted by public agencies.

Speed Up Salk Vaccine Distribution Plans, States Urged

Members of the National Advisory Committee on Poliomyelitis Vaccine, meeting June 23 in the Department of Health, Education, and Welfare, recommended that States take immediate action to develop and implement plans for assuring equitable distribution of the Salk vaccine. Commented the committee: "Success of the voluntary plan is dependent to a major extent upon the development of effective State plans." Plan should include a system for obtaining reports of shipments from manufacturers and of sales from retail outlets. Other recommendations:

1. For the time being, the 5 through 9 priority group should be adhered to, and as vaccine becomes available, the committee will broaden the group to include equal additions above and below the present priority ages.

2. All available means should be utilized to develop a coordinated nationwide educational campaign this summer to assist health departments and physicians in keeping the public informed about the poliomyelitis vaccine program.

Those attending the meeting were: Dr. Chester S. Keefer, special assistant to Secretary Hobby, chairman; Dr. Philip S. Barba, American Academy of Pediatrics; Dr. Daniel Bergsma, New Jersey Health Commissioner; Dr. Robert P. Fischelis, American Pharmaceutical Association; Mrs. Richard Radue, National Congress of Parents and Teachers;

Frank W. Moudry, National Association of Retail Druggists; Dr. Malcolm Phelps, American Academy of General Practice; Dr. Julian P. Price, trustee of the American Medical Association; Dr. George M. Uhl, Los Angeles city health officer; and Mrs. Charles L. Williams, National Congress of Colored Parents and Teachers Association.

During House Interstate and Foreign Commerce Committee hearings June 22-24 on the technical aspects of the vaccine, the question arose over the advisability of suspending inoculations this year and concentrating on the development of the vaccine using weaker polio strains. Dr. Albert B. Sabin of Children's Hospital Research Foundation at Cincinnati advocated this and was supported by Dr. John F. Enders of Children's Hospital in Boston, and Dr. William McD. Hammon of the University of Pittsburgh. The three men are listed as members of the 15 man advisory committee that recommended the vaccine be licensed following the April 12 announcement of the evaluation of last year's field trials. The majority of the panel appearing before the House committee, however, favored continuing the program, although in some cases their views were qualified.

Tax Exemption for Sick Leave Wages

Internal Revenue Service has issued a ruling involving the seven day waiting period required before sick leave wages may be considered as tax exempt. The Service rules that the first seven days of job absence because of sickness satisfy this requirement, even if not taken in the year for which tax exemption is claimed.

Miners' Medical Program Yields to AMA Criticism

Responding to criticism by AMA, medical program of United Mine Workers Welfare & Retirement Fund has canceled its directive requiring consultations with specialists prior to hospitalization of beneficiaries. Dr. Warren F. Draper, executive medical officer, stated that upon his return from Atlantic City—where censure of the policy was adopted—he wrote to all area medical administrators advising them that the disputed consultations would not be required. Thus there will be no "interference" with attending physician, as was charged in Atlantic City.

Reorganization of Biologics Control Ordered at PHS; Law Reviewed

In his technical report on the Salk poliomyelitis vaccine to HEW Secretary Hobby, Surgeon General Scheele disclosed: (1) formation of a Division of Biologics Standards, replacing the Laboratory of Biologics Control, and (2) a review under way by PHS of the Biologics Control Act of 1902 (under which the Salk vaccine was licensed for manufacture) with a view of possible amendments by Congress.

To head the new division, Dr. Scheele has brought in Dr. Carl L. Larson, director of the PHS Rocky Mountain Laboratory at Hamilton, Montana; his assistant will be Dr. William G. Workman, who has headed the biologics laboratory which was involved in the licensing of the polio vaccine.

Dr. Scheele said the testing program of the new division will be directed primarily toward determination of the exact significance of safety and potency tests, and modification of tests and their interpretations "to make test data yield more penetrating information." He also said investigations of the preceding five weeks indicate records required of pharmaceutical firms making the vaccine were "inadequate to permit realistic assessment of consistency in performance . . . since they related only to lots of vaccines submitted for clearance and gave no information on lots discarded in course of manufacture."

The Surgeon General noted that events in connection with the Salk vaccine which traditionally would have covered years were "telescoped into months, and, as a result, both successes and failures have been magnified. In the long run, however, the nation and the world will surely have gained from efforts to speed the availability of an effective immunizing agent against this disease."

Federal Grants

The Public Health Advisory Committee of the Commission on Intergovernmental Relations submitted its report to the President June 28. The advisory committee recommended continuance at present level (about \$57 million per year) of Federal grants to States for maternal and child health, tuberculosis, venereal disease, cancer and heart control, and general public health activities. It indorsed Hill-Burton hospital program, but urged that voluntary

health agencies be called upon for counsel before Congress grants this undertaking another extension (it is due to expire in 1957). Federal financial support of medical research was heartily indorsed. In matter of professional training, the committee recommended establishment of public health fellowships but warily avoided taking a stand on subsidies for medical schools pending "an entirely objective study of this problem." Like the Hoover Commission and its medical task force, Murphy committee favored creation of a Federal Health council to coordinate.

Need For Medical School Scholarships

ALAN GREGG, M.D., *Vice President,
Rockefeller Fund on Special Assignments*

The fact is that young people decide to try for entrance to medical schools, or to give up that hope, more often at the end of high school than at any other time. It is a critical moment and a grave decision: as grave and critical for us as for them. To decide at 18, after 12 years of schooling, to go into medicine implies 12 years more of schooling before complete freedom in the way of earning one's living in medicine can be expected. So if we were to seek through scholarships to increase the number or improve the quality of the entrants to our profession, I am convinced that such scholarships should be given as early as the end of high school. That is when an unknown number of excellent young men relinquish for lack of money the hope of going into medicine. This situation becomes more grave if we think the character and ability of our successors as important as their monetary resources. At present too much depends on whether a young man has enough money to be a student for 12 years after high school. "He travels fastest who travels alone"—so runs the proverb. If translated into the language of our professional recruitment, it could be expressed as: The boy who has no financial responsibility for any other members of his family, and whose family can afford to give him 12 years' medical education, can get it; but the poor boy with a strong sense of loyalty to the other members of his family, unselfishly and quietly may give up his hope of going into medicine—so quietly indeed that we doctors do not know our losses of such recruits.

Reprinted from *Bulletin of the American College of Surgeons* with permission of editor and author.

OBITUARY

Alfred J. Sette

1900 - 1955



Alfred J. Sette was born in Derby, Connecticut, December 16, 1900 and he died suddenly at the Stamford Hospital, March 12, 1955 of acute leukemia.

After graduating from Derby High School, Dr. Sette matriculated at Catholic University and Columbia University; and in 1927 he was graduated from George Washington University Medical School with the degree Doctor of Medicine.

He interned for one year at St. Raphael's Hospital in New Haven, and in 1928 he opened an office in Stamford, Connecticut for the general practice of medicine. Ever a devoted student of medicine, and realizing early in his career that he possessed a natural inclination toward surgery, Dr. Sette diligently applied himself to further study and post-graduate training in this specialty. In 1940 he was appointed to the regular surgical staff of the Stamford Hospital as assistant attending surgeon; and in 1942 he received a similar appointment at St. Joseph's Hospital. Later, having restricted his practice to surgery, he was appointed to the senior attending staff at the Stamford Hospital. Because of

his natural ability for organization and his interest in medicine in general, he was appointed director of clinics at the Stamford Hospital in 1951.

On September 23, 1929 he married Miss Margaret Dinofrio of Boston, Massachusetts. To them were born a son, Alfred J. Sette, Jr.; and a daughter, Miss Mary Louise Sette.

Dr. Sette entered the service of his country in World War II and served for three years as Lieutenant Commander and Commander in the U. S. Navy. After completing a tour of duty as Chief of Surgery at the New London Base, he was assigned as Senior Medical Officer on ships involved with operations and evacuating casualties from Eniwetok, Ulithi, Iwo Jima and Okinawa.

Always mindful that differences and inequities—be they real or fanciful—can and do exist between doctor and patient, Dr. Sette early pioneered for some means to settle these differences amicably and fairly. His dogged and persistent efforts resulted in the formation of a grievance committee in Stamford; he was its first chairman.

Not satisfied with the ultimate success of this project in Stamford, Dr. Sette carried his ideas to a higher level and soon was appointed chairman of the Public Relations Committee of the Fairfield County Medical Association, and member of the Public Relations Committee of the Connecticut State Medical Society. In a vast measure the success of the medical exhibit at the Danbury Fair and in many hospitals throughout the State was due to his painstaking and untiring efforts.

Dr. Sette was a member of the Stamford Medical Society, the Fairfield County Medical Association, the Connecticut State Medical Society and the American Medical Association. He was a past president and secretary of the Stamford Medical Society, and a trustee of the Fairfield County Medical Association. He served as secretary of the Surgical Section of the Stamford Hospital; and was a Fellow and Diplomate of the International College of Surgeons. His many civic accomplishments included active participation in the direction of activities of the local chapter of Boy Scouts of America and membership on the Board of Directors of the At-

lantic Industrial Bank, the Italian Institute and the Italian Center.

For many years there appeared as a regular feature of the CONNECTICUT STATE MEDICAL JOURNAL a column entitled, The General Practitioner's Forum. Filled with tidbits of medical wisdom, it proved stimulating reading not only to the general practitioner but also to all physicians. Although this section in the JOURNAL always bore the signature T. P. R., M.D., only recently has it come to light that Dr. Sette was its author.

Despite an active medical practice, Dr. Sette found time for a few hobbies. He took great pride in his ability as an amateur photographer, and in his knowledge of the basic principles of gardening. With the growth of amateur radio transmission, he was one of the first "hams" licensed by the F. C. C. in this area.

Those of us who were privileged to know Al will always remember him with love and respect for his simplicity, sincerity and honesty. His life was exemplified by a true respect for the dignity of man; a fervent devotion to the principles and ideals of justice and fair play; and an unselfish dedication to his country, his community, and his profession.

Upon learning of his all-too-sudden departure, we were constrained to add our sorrow to this lament of the poet:

"He bade no one a last farewell,
He said good-bye to none;
The heavenly gates just opened wide,
A loving voice said, 'Come.'
God knew that he was suffering,
That the hills were hard to climb;
So he closed his weary eyes
And whispered, 'Peace be Thine'."

Truly, we have lost a dear and intimate friend.

Angelo Mastrangelo, Jr., M.D.

Preschool Institute for the Blind Child and His Parents

The Preschool Institute is being planned to meet the needs of parents who would like help with their visually handicapped, preschool children through conferences and lectures. There will be opportunities for the mothers to listen to speakers, both professional people who are experts in their fields and parents who have experienced problems with

their blind children. There will be opportunities for mothers to discuss their problems with other mothers and with staff members, as well as to participate in social activities with them. There will be trained and competent baby sitters to take care of the babies while the mothers are attending lectures, eating, and participating in recreational activities.

It is hoped that these parents will benefit from the professional advice available at the conferences and lectures. It is hoped also that they will be reassured as to the services available for their children so that they may receive an education and training sufficient to make them independent citizens.

For detailed program see Special Notices in this issue.

Further information and application forms for this Preschool Institute may be obtained from Mr. Frank Johns, Jr., superintendent, 120 Holcomb Street, Hartford, Connecticut.

THE DOCTOR'S OFFICE

William F. Burke, M.D. announces the opening of an office for the practice of general medicine at Main Street, Newtown.

Michael Eilbergas, M.D. announces the removal of his office from 110 Main Street to 2 Spring Street, Windsor Locks.

Myron E. Freedman, M.D. announces the opening of an office for the practice of internal medicine and cardiology at 10 North Main Street, West Hartford.

James J. Griffith, M.D. announces the opening of an office for the practice of internal medicine at 272 West Avenue, Norwalk.

Jamil A. Karsh, M.D. announces the opening of an office for the practice of gynecology and obstetrics at 18 Central Avenue, Waterbury.

Edwin J. T. Moore, M.D. announces the opening of an office for the practice of obstetrics and gynecology at 168 Prospect Street, Waterbury.

William J. Roger, M.D. announces the opening of an office for the practice of obstetrics and gynecology at 520 West Avenue, Norwalk.

Howard J. Wetstone, M.D. announces the opening of an office for the practice of internal medicine at 299 Farmington Avenue, Hartford.

LETTERS TO THE EDITOR

Objects to Bricker Amendment

June 27, 1955

To the Editor:

Until I read the News From Washington in the June, 1955 issue of the CONNECTICUT STATE MEDICAL JOURNAL I had never heard of F. E. Wilson, M.D., director Washington Office. Never having made his acquaintance I think that it was extremely nice of Dr. Wilson to tell me how to think about the Bricker amendment. I assume that he included me in his disquisition since I am a member of the AMA and he says that "the AMA indorses the principle of the Bricker amendment . . ." which "the doctors want . . ." I certainly don't want Dr. Wilson to feel that I am ungrateful for his advice on how to think about a national issue but I wonder if this isn't a case of cart-before-the-horse-ism. (There are so many isms today I hope Dr. W. won't mind another one.) Before Dr. Wilson or some of the headquarters boys go up on the Hill and tell the committees how all the members—more than 150,000—of the AMA want this bill passed or that one defeated, wouldn't it be a good idea to find out how all these members do feel? In the two years that the Bricker amendment has been discussed surely there was time for at least a small sampling of opinion. I don't like to think that the officials of the AMA feel that we here in the grass roots (as they like to put it) are too busy to have an opinion or are too preoccupied with our appendectomies, colds, deliveries, and Colles' fractures to care what goes on in Washington. I especially don't want them to tell the Senators how we all feel before they tell us. Unless, that is, they can think up some better reasons than Dr. Wilson did.

Dr. Wilson likes Senator Bricker's amendment because he thinks Thomas Jefferson would have liked it. How he found this out I can't discover, but it seems to me that everybody who wants something done in Washington says that Thomas Jefferson would have been on his side. If it isn't Thomas Jefferson it's Abraham Lincoln, or Samuel Adams, or Patrick Henry. As far as I know, no one has invoked the spirit of Davy Crockett yet but the way

things are going it might be a good idea to have him on your side if you want to get your bill passed.

The only other reason I can dig out of the article is that "treaty provisions have injected themselves into some medical areas, and under present law they constantly threaten greater interference." I can't find out at the moment how a treaty has interfered with my practice, but I guess if this is true we ought to be against treaties or at least against any we find injecting themselves, etc. This brings us finally to the conclusion that "what's best for the AMA is best for the nation" to paraphrase another leading figure. Dr. W. didn't say this directly but it's the only conclusion I can come to after reading his article.

This conclusion doesn't quite fit in with all I read these days in the Journals about doctors being public spirited and taking an interest in civic affairs, and being leaders of the community and all. To do this we have to be citizens first and doctors second and perhaps give up a few vested interests in the public interest.

Let me hasten to assure Dr. Wilson that I'm just as much against "socialized medicine" as he is. Only I'm not afraid that it's going to creep in the back door or through the side window or even down the chimney. I don't believe in ghosts either. I do believe that as communications and education improve throughout the world there is just a slight chance that perhaps someday we may be able to do away with war, and pestilence, and famine. If that day comes and it's time to sign a treaty I don't want Senator Bricker or any of the other supernationalists blocking it with their plans to have it approved by all the legislators and superpatriots they want to include in the deal.

I believe that if the policy-making body of the AMA acted in a statesmanlike manner and put the national interest ahead of our own selfish interest they would be lobbying against the Bricker amendment instead of for it. Perhaps it might be a good idea in the future for Dr. Wilson and his friends to find out how we all feel before they commit us on a national level.

Frederick W. Goodrich, Jr., M.D.

342 Montauk Avenue
New London, Connecticut

Ed.: A reply to this letter is printed on page 679.

"Cases and Observations"

To the Editor:

The historical note and copy of the old letter referring to "Cases and Observations," published in the June issue of the *STATE MEDICAL JOURNAL* was of particular interest to me.

The little volume of "Cases and Observations" is a most historical publication and believed to be the first medical publication in America. It is much sought after and copies of the original are very rare. The whole volume was reprinted from facsimile zinc plates in the *Yale Journal of Medicine* at the time of the celebration of the 105th anniversary of the founding of the New Haven Medical Association in 1932.

John Morgan, who wrote the letter that Merrill Lindsay showed to Dr. Blanchard, was one of the most prominent physicians in America in his time. He lived in Philadelphia, was a distinguished scholar and more responsible than any other for the founding of the medical school in the University of Pennsylvania.

Benjamin Rush wrote a long biography of him and he has taken his place among the great medical men in colonial times. I am not familiar with the volume he mentions in the letter, actually the title is not given and I can not identify it in the partial bibliography of Morgan referred to by James Thatcher in his *American Medical Biographies*.

Dr. Blanchard's guess about the Bronsons is probably a good one. Henry Bronson might well have had the letter in his possession sometime. He was the great Connecticut medical biographer and president of the Connecticut State Medical Society in 1869.

Sincerely yours,
Creighton Barker, M.D.,

Cancer Drive Successful

The Connecticut Division of the American Cancer Society announced at its final fund drive dinner in June that a record breaking sum of \$536,955 had been raised during the 1955 campaign. In his semi-annual report as president, Dr. Ashley W. Oughterson said that cancer control activities in Connecticut have grown to a point where requests for funds substantially exceed the amount raised. He also reported that the American Cancer Society returns to the State for research and fellowship work at Yale, Wesleyan, and the University of Connecticut a larger sum than the share of proceeds it derives from the campaign in this State.

Connecticut Committee on Foods, Drugs, Cosmetics and Devices Meeting of March 31, 1955

The member societies and institutions were represented at this meeting as follows: Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut State Dental Association, Dr. William Kirschner; Connecticut State Medical Society, Dr. Hugh Dwyer; Connecticut Veterinary Medical Association, Dr. Joseph DeVita; University of Connecticut, Dr. Stanley E. Wedberg; Yale University School of Medicine, Dr. Desmond D. Bonnycastle.

The following were also present: Dr. Felix Blanc, representing the Pharmacy Commission; Dr. Barnett Greenhouse, chairman of the Joint Committee of the State Medical Society and the Pharmaceutical Association; Dr. James C. Hart, representing the State Department of Health; Mr. Herbert Plank, representing the Food and Drug Commission; Dr. J. McCullough Turner, State Representative for Bethany.

"ELECTRO THERAPEUTIC BRACELET"

A circular for a product of the above name, made by Thermopile Department, Metallic Flowers, Inc., 328 East 95th Street, New York 28, N. Y., was passed around. The circular called this device: "A modern addition to the ambulatory treatment of muscle and joint aches, pains and body afflictions," and described it as follows:

"What It Is

"The Electro-Therapeutic Bracelet (E.T.B.) is a delicately constructed electrical apparatus which has been artfully camouflaged as an attractive article of jewelry. The centerpiece of molded plastic and metal is formed to fit comfortably against the curve of the wrist, to which it is secured by a stainless steel expansion band.

"The heart of the Electro-Therapeutic Bracelet (E.T.B.) resides in its attractive center housing of plastic and metal and conceals within its body a miniature electric generator called a thermopile which converts thermal energy into electrical energy. In its practical application, when the concave face of the E.T.B. is secured to the wrist it is activated by the differences between the body heat and the environmental or seasonal temperature to which its opposite surface is exposed, and a small electric current is created and flows around the bracelet. The magnitude of this generated current is proportional to the differences in temperatures of the two opposing faces of the instrument, but in no instance can it ever exceed decimal fractions of intensity. Generally, no more than one thousandth of a volt is ever active at any one time."

Drs. Greenhouse and Dwyer both said that they knew people who wore things like this, and Dr.

Dwyer added that he would agree to condemnation of the product as having no medicinal value.

"TUCO BED BOARD"

A piece of heavy brown paper about 16½" x 18½" cut from the wrapping of a "Tuco Bed Board" was displayed to the members; it was labelled in part "Restful Sleep on a Tuco Bed Board Often Recommended by Doctors for Sufferers of Sacro-Iliac, Arthritic and Other Spinal Ailments. The Tuco Work Shops, Incorporated, Lockport, New York." Mr. Plank said that the board itself was made of plywood.

Dr. Dwyer remarked that this was a very commonly prescribed thing; most people went to a lumber yard for it, but if it were sold in drugstores so much the better; this was the first exhibit he had seen yet that he could approve.

"GRECIAN FORMULA 16"

Mr. Plank said that a product of the above name was being sponsored by Suzanne Silvercruys Stevenson, the well known sculptress. He showed to the members a clipping from the *Bridgeport Post* of March 11, 1954 about Mrs. Stevenson, and a circular and booklet about the "Grecian Formula 16" put out by Look Young, Inc., 362 Main Street, Willimantic, Connecticut. The first page of the booklet carried the statement "Grecian Formula 16 restores gray hair to natural looking color," and it was the "Restores . . . natural . . . color" that he objected to.

After some discussion it was voted, on motion of Dwyer, seconded by Kirschner, that the Committee consider the claim fraudulent unless the promoters could prove that it was not.

THE SALK VACCINE

Dr. Hart said that all the local directors of health had met in Newington on March 31 to discuss plans for mass immunization of 121,000 Connecticut children—all first and second grade children and those third and fourth graders in Hartford and a few other places who had taken part in the original tests and received placebos instead of vaccine. The vaccine would also be on sale in drugstores after April 12 at prices to each doctor of between \$4.20 and \$4.50 for each immunization. He had attended the legislative hearing on a bill to appropriate \$100,000 to buy vaccine for the medically indigent, and had been informed immediately after the hearing closed that the bill would go through. The State

Department of Health had received a very favorably priced quotation (\$1.87 per immunization) from Eli Lilly & Co. to supply the vaccine to be paid for by this appropriation. No specifications for the age limits within which this vaccine would be given had been set as yet, but it was known that children under six months old had the antibodies and that people were susceptible up to the age of 40.

Dr. Wedberg said that what was called "serological maturity" was not reached until the age of six months.

Dr. Hart added that they would be pressed for time, since if they started school immunizations in May they would be hard set to get the third injection in before the schools closed. The druggists already had the vaccine on their shelves, but of the manufacturers only Eli Lilly and Parke, Davis had much to sell.

Meeting of May 26, 1955

The member societies and institutions were represented at this meeting as follows: Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut Pharmaceutical Association, Prof. Nicholas W. Fenney; Connecticut State Dental Association, Dr. William Kirschner; Connecticut State Medical Society, Dr. Barnett Greenhouse; Connecticut Veterinary Medical Association, Dr. Joseph DeVita; University of Connecticut, Dr. Stanley E. Wedberg; University of Connecticut College of Pharmacy, Dean H. C. Hewitt; Yale University School of Medicine, Dr. Desmond D. Bonnycastle.

The following were also present: Dr. James C. Hart, representing the State Department of Health; Mr. Herbert Plank, representing the Food and Drug Commission.

THE HAZARDOUS SUBSTANCES BILL

Mr. Plank reported that quite a hearing had been held before the Public Health and Safety Committee (Senator Fishman presiding) on April 27. Before the meeting he had had lunch with A. G. Cranch, M.D., medical consultant for the Union Carbide and Carbon Corporation, and Frank D. Curtis, attorney from the legal department of Merck & Co., Inc., who were serving as representatives of the Committee on Labels and Precautionary Information of the Manufacturing Chemists' Association. The two had paid fees to register as lobbyists so that they could testify at the hearing.

"No one at the hearing had actually opposed the bill in principle, and no objections to details were raised by anyone except Dr. Cranch and Mr. Curtis. Dr. DeVita had started the testimony for our side and had supervised the order in which our witnesses

appeared. Dr. Josephs, president of the State organization of the pediatricians, had presented statistics on the number of deaths from accidental poisoning in the State and the country at large and how these compared with deaths of children from poliomyelitis and other diseases. Representative Turner gave a very clear exposition of the bill and explanation of why its passage was so important, and numerous other legislators appeared and registered in its favor. Drs. Bonnycastle and Hewitt both spoke for the bill. (Because the secretary of the Committee was absent in Washington, D. C. and consequently unable to attend the hearing, he has had to rely on his recollections of Mr. Plank's report for this account of what happened; there may therefore be omissions, and some Committee members and others may have testified who are not credited here.)

"After the hearing I brought Mr. Curtis back to New Haven to catch a train. During the ride Curtis suggested certain changes in phraseology which were later adopted; and after Dr. Cranch and Mr. Curtis had gone home they sent a letter to Senator Fishman embodying all their suggestions for amendments. The subcommittee of our Committee had adopted most of these suggestions, including their more elaborate definition of 'Poison.' When these changes were shown to Senator Fishman he had said that they were all right and to take the finally revised bill down to Mr. Wall, the Legislative Commissioner. This had been done, and while Mr. Wall had questioned individual words he had made no actual changes except to run several sections together. Mr. Turner had reported that he thought the bill would go through, and that was the last I had heard until Mr. Cole (secretary of the Joint Committee of the State Medical Society and the Pharmaceutical Association) had told me at the last Joint Conference Committee meeting that he had heard that the Committee on Public Health and Safety had decided not to report the bill out. Just about that time there had been an article in the *Hartford Courant* about a boy who swallowed a hair rinse and his doctor's difficulties in trying to contact the manufacturer and find out what was in the hair rinse so that he would know how to treat the boy."

Dr. Fisher followed Mr. Plank to report that on May 25 Representative Turner had called him on the telephone and confirmed that the Public Health and Safety Committee would either bury the bill in committee or report it adversely. If it should be reported out of committee Turner promised that

he would speak for the bill on the floor of the House; he also said that he had told his party associates that he could not prevent our Committee's carrying the case to the newspapers.

Dr. Bonnycastle remarked that more kids died from household poisoning than from polio—500 a year in the United States; Dr. Josephs could give the actual figures.

On motion of Hewitt, seconded by Wedberg, it was voted unanimously that the chairman (Dr. DeVita) be appointed a subcommittee of one with authority to contact the Associated Press and other news sources and take such other steps as he deemed necessary (including contacts with members of the Legislature and other persons) to assure passage of the bill; and that he be authorized to call on any Committee member for such help as he desired.

It was agreed that each Committee member present would report back to the governing body of his association or institution on what had happened to the bill, and would solicit their support in getting the bill passed.

As a matter of information, the following very abbreviated summary of the history of the bill before and after the May 26 meeting is outlined herewith:

(1) The existence of the New York hazardous substances law was called to the Committee's attention by Dr. Bonnycastle on October 7, 1954. Copies of the law were secured from Dr. Johnston of the State Department of Health on December 2, 1954, and at that meeting the representative of the Pharmaceutical Association (Prof. Fenney) proposed that the Committee "look into the possibility of adopting in Connecticut a law like that of New York."

(2) Prior to the meeting of January 27, 1955 Representative J. McCullough Turner of Bethany offered to introduce a bill based on the New York law if the Committee would actively back it.

(3) At the January 27 meeting the Committee voted unanimously to back such a bill and to have each member "inform his respective governing body of the action of the Committee and solicit their support." At this meeting the representative of the State Medical Society (Dr. Dwyer) remarked "that from the standpoint of public safety we were all agreed that we ought to have a labelling law; this was our opportunity and we ought to do what we could." A subcommittee composed of Plank (chair-

man), Fenney and Hewitt was appointed to draw up a final revision of the bill.

(4) Letters were received from the secretaries of the State Medical Society and the State Dental Association, as well as Health Commissioner Osborn, endorsing the Committee's bill without reservation. Dr. Barker's letter of March 30 and the statement of the Committee on State Legislation of the State Medical Society of March 21 (as reproduced in the March 31 Report) made their endorsement not only in general terms but specifically for HB1887, which was the revised bill of our subcommittee.

(5) The formal hearing before the Committee on Public Health and Safety on April 27 produced no opposition to the bill other than on technical details. (See the account of this hearing in this Report.)

(6) On May 25 Representative Turner informed the Committee that the bill would either be buried in committee or reported out adversely. On June 11 Mr. Turner submitted a formal statement on the legislative progress of the bill.

(7) After the May 26 meeting the chairman, Dr. DeVita, as authorized by the Committee, took the matter to the Press, and with the active support of some members of the Committee also approached everyone whom it was thought might have influence in getting the bill passed, first at the regular session and later at the following special session of the General Assembly. In spite of a great deal of enthusiastic help (particularly from the pediatricians, dentists and veterinarians) the fate of the bill was as follows: (a) At the regular session one copy was referred by the House to the Legislative Council for study, while an identical copy was passed unanimously by the Senate and buried in committee by the House; (b), at the special session the bill was raised again and passed by the Senate but buried in committee by the House.

INFORMATION SERVICE ON ANTIDOTES FOR HOUSEHOLD POISONS

Dr. Bonnycastle reported that a week after the hearing Dr. Plessen had come down to see him with an almost completed list, which he was going to check with Dr. Josephs and then publish. The list should appear very shortly now.

"RICHARD HUDNUT NEW DISCOVERY PIN QUICK LANOLIZED PIN-CURL PERMANENT"

Mr. Plank reported that a complaint had recently been received by his office that a permanent wave preparation of the above name, made by Richard

Hudnut of New York and Paris, had caused burns on a user's face and had even caused her skin to peel off. He had submitted a sample to Dr. Fisher for analysis, and had received the follownig reply:

"Composition of the wave lotion from our analysis was as follows:

	"Gm./100 cc.
"Ammonium thioglycollate	6.83
"Free ammonia (NH ₃)	0.89
"Lanolin and wetting agent by difference.....	0.72
"The pH was 9.30.	

"This product contains an ammonium rather than the sodium or ethanolamine salts of thioglycollic acid that are more commonly found in permanent wave preparations. Probably the reason for its caustic effect was the combination of the free ammonia with a wetting agent that made the skin more readily penetrated by the ammonia.

"I believe there is a serious question here whether this is not more than the usual allergy case; perhaps the formulation is such that this product is actually a primary irritant that should be considered adulterated 3947(a). If complaints about the same product come from a number of different sources I would be disposed to recommend that you embargo it and try to get expert advice to back up your stand.

"Your very truly,

"Harry J. Fisher,

"Chief Chemist"

Mr. Plank said that he had had complaints from two drugstores that customers had found this wave preparation to be too harsh.

After some discussion about the quantity of free ammonia present and the possible effect of the wetting agent in increasing any caustic action, it was agreed that the sample be turned over to Drs. Hewitt and Wedberg to conduct skin tests on their pupils.

On June 3 Dr. Hewitt reported to Dr. Fisher on the above tests as follows:

"As a result of the request of the Committee . . . we subjected 30 junior students to a skin test with a sample of the Richard Hudnut Pin Quick Lanolized Pin-Curl Permanent with Magic Curl-Control. Dr. Wedberg did the application as the time was such as to find it tough for me to join in the experiment. However, he did the testing on the skin.

"This preparation was allowed to stand in contact with the skin on the forearm for a period of 10 minutes. In not one of the 30 students tested was there any redness or any indication of any irritation."

"DANDRICIDE ANTI DANDRUFF RINSE"

Mr. Plank and Dr. Fisher showed the members a bottle of a preparation of the above name made by King Research, Inc., Brooklyn 15, N. Y. Dr. Fisher had expressed an opinion to Mr. Plank that "a product sold 'specifically for dandruff' (as this was) is an article 'intended for use in the . . . cure, mitigation, treatment or prevention of disease in man' (3930(g)(2)), and therefore a drug within the meaning of the law." If this opinion were correct it would mean that "Dandricide" would have to list its active ingredients on the label; before requiring the manufacturers to do this, Mr. Plank wanted a separate opinion from the Committee.

This question was discussed at some length by the Committee. There was no general agreement that dandruff was always a disease, but there was agreement with Prof. Fenney's argument that since etymologically "Dandricide" plainly meant "Dandruff Killer" the manufacturers themselves obviously thought of the product as a drug. On motion of Fenney, seconded by Wedberg, it was voted that the Committee consider "Dandricide" a drug because of its name.

"TES-TAPE"

Dr. Greenhouse showed the members a roll of tape of the above name (Urine Sugar Test Tape Lilly) which was shortly to be put on the market by Eli Lilly & Co. as a replacement for Benedict's Solution and other reagents for testing for sugar in urine. He demonstrated with a glass of maple syrup the color change produced in the tape by sugar. He said that the tape was treated with glucose oxidase and turned blue in the presence of glucose; the reaction was so specific for glucose that the tape would not react to any other sugar or other reducing substance. Comparison with a color chart accompanying each roll enabled the percentage of sugar in the urine to be estimated. It had not been possible to impregnate all tape so uniformly that one color chart would be accurate for every roll, so a separate chart was standardized for each lot. Each roll contained enough tape for 100 tests. This tape was bound to be a great convenience, because any diabetic could test himself anywhere at any time just by wetting a strip of the tape with his urine.

St. Vincent's Hospital Celebrates

An "Open House" with an estimated attendance of more than 2,500 visitors was the feature of the 50th anniversary of the founding of St. Vincent's Hospital, Bridgeport, on Sunday, June 28.

In addition to escorted tours to all hospital departments, the event provided 26 exhibits, most of them of a scientific nature, arranged for public visitation in the nurses' auditorium.

The event was described by the arrangements committee as an "all out effort by the doctors and the hospital to better public relations" by providing a first-hand inspection and study of the functions of a modern hospital. The event also sought to depict graphically the growth and diversity of the hospital's services to patients and the need for increasing the departmental personnel to keep up with the newest advances in medicine, hospital care and training.

Several of the exhibits adopted the anniversary theme, revolving their displays about medicine as it was practiced in 1905 when the institution was established and showing diagnostic equipment and treatment improvements which have taken place in the last 50 years.

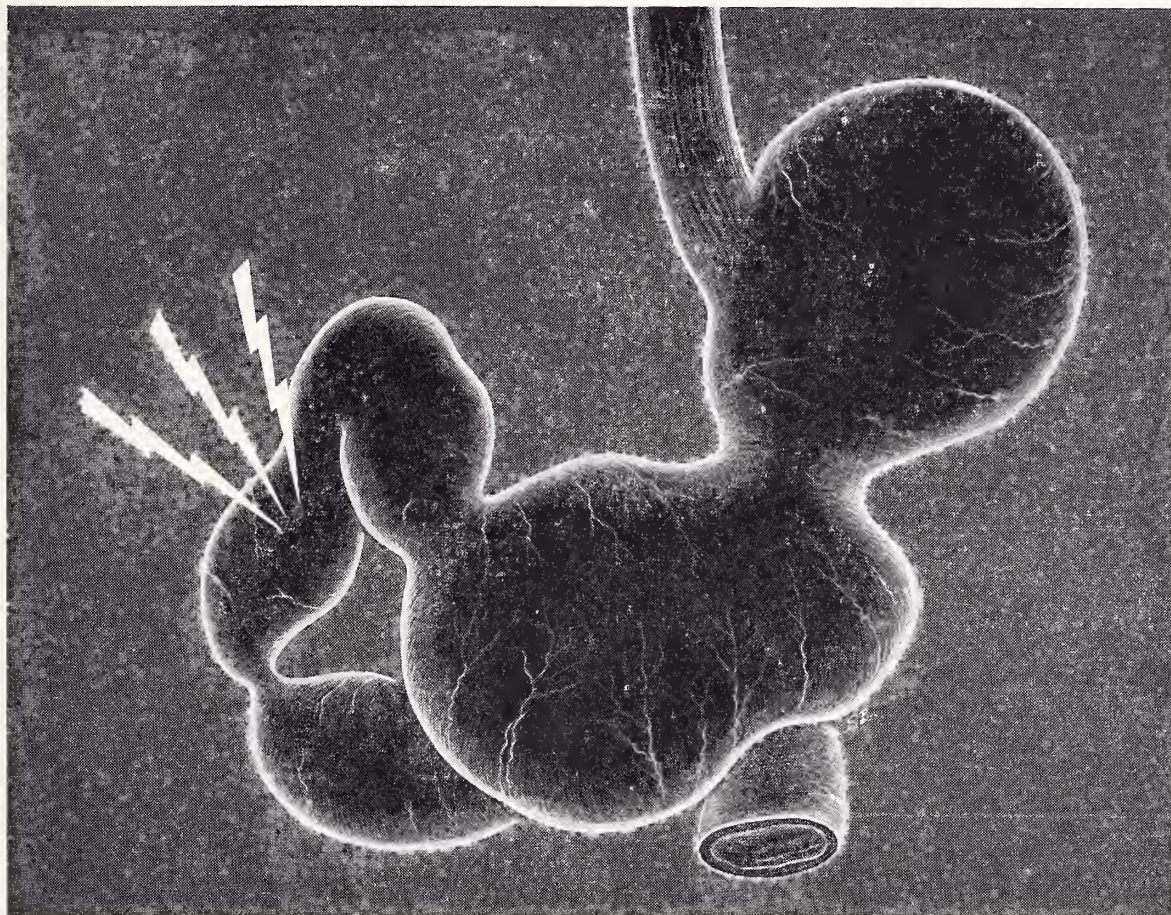
With the exception of two displays on medical and hospital care payment plans, the exhibits were developed and staffed by hospital physicians or nurses. The arrangements committee awarded three trophies for exhibits, which in the opinion of a panel of judges representing varied community viewpoints were found to be outstanding.

John M. Murphy of the hospital lay staff served as general chairman with Sister Marie, administrator, as cochairman and assisted by representatives of the medical staff and other hospital organizations.

A committee headed by Michael A. Dean and composed of hospital staff members made all of the arrangements for the scientific exhibit.

The golden anniversary year was also noted in a Pontifical Mass celebrated by His Excellency, the Most Rev. Lawrence J. Shehan, Bishop of Bridgeport, in ceremonies held at St. Augustine's Cathedral, Bridgeport.

PRO-BANTHINE FOR ANTICHOLINERGIC ACTION



Abnormal Motility as the Cause of Ulcer Pain

Until recently the general opinion was held that ulcer pain was primarily caused by the presence of hydrochloric acid on the surface of the ulcer.

Present investigations^{1,2} on the relationship of acidity and muscular activity to ulcer pain have led to the following concept of its etiologic factor:

"... abnormal motility² is the fundamental mechanism through which ulcer pain is produced. For the production and perception of ulcer pain there must be, one, a stimulus, HCl or others less well understood; two, an intact motor nerve supply to the stomach and duodenum; three, altered gastro-duodenal motility; and four, an intact sensory pathway to the cerebral cortex."

Pro-Banthine® has been demonstrated consistently to reduce hypermotility of the stomach and intestinal tract and in most instances also to reduce gastric acid-

ity. Dramatic remissions¹ in peptic ulcer have followed Pro-Banthine therapy. These remissions (or possible cures) were established not only on the basis of the disappearance of pain and increased subjective well-being but also on roentgenologic evidence.

Pro-Banthine Bromide (Beta-diisopropylaminoethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) has other fields of usefulness, particularly in those in which vagotonia or parasympathotonia is present. These conditions include hypermotility of the large and small bowel, certain forms of pylorospasm, pancreatitis and ureteral and bladder spasm.

1. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: A Clinical Evaluation of a New Anticholinergic Drug, Pro-Banthine, *Gastroenterology* 25:416 (Nov.) 1953.

2. Ruffin, J. M.; Baylin, G. J.; Legerton, C. W., Jr., and Texter, E. C., Jr.: Mechanism of Pain in Peptic Ulcer, *Gastroenterology* 23:252 (Feb.) 1953.

SEARLE

ANNUAL REPORTS

OF THE CONNECTICUT STATE MEDICAL SOCIETY

1954 - 1955 (Concluded)

REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Newell W. Giles, Chairman

Morton Arnold	Winfield O. Kelly
Barnett P. Freedman	Frank L. Polito
Orvan W. Hess	Alfred B. Sundquist
Jacques VanB. Voris	

The members of the Advisory Committee have been called upon from time to time for advice. We have tried to be as helpful as possible in discussing and attempting to solve the problems brought before us, consulting other authority when necessary.

We have received invitations to attend both County and State Auxiliary meetings and usually at least one member has been present. We regret that it has not always been possible for more of us to attend these meetings.

Respectfully submitted,
Newell W. Giles

REPORT OF THE COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Chairman

Egbert M. Andrews	Norton Canfield
Joseph J. Bruno	Joseph N. D'Esopo
George A. Buckhout	Benjamin M. Shenker

The Connecticut Home Town Medical Program for Veterans has again been conducted this year without registration of a single grievance, either by physicians, representatives of the Veterans Administration or individual veterans.

This marks the second successive year this has occurred and the Committee feels it indicates highly commendable cooperation between physicians and the Hartford Regional Office of the Veterans Administration.

At the end of the year, there were 1,550 physicians enrolled in the program as compared to 1,500 physicians the previous year. This rate of growth in physician participation has continued steadily since the program was inaugurated in 1946 with an enrollment of only 400 physicians.

Compared to Connecticut's veteran population of approximately 326,000, this means that there is one fee basis physician for approximately every 215 veterans. This is believed to be one of the highest ratios in the country.

During the fiscal year, July 1, 1953 through June 30, 1954, 14,186 veterans received medical care for service con-

nected disabilities under this program. The total treatments for this group numbered 28,504, at a total cost of \$139,735.

The contract and attendant schedule of fees under which the program operates was negotiated with the Veterans Administration in May 1954 under the same terms as the previous year. The contract for the next fiscal year will be in the hands of the Committee some time during May for review and renewal before the end of the present fiscal year on June 30.

Last January the Committee was invited to send a representative to a Chicago Conference sponsored by the American Medical Association's Committee on Federal Medical Services. This Conference was attended by Dr. Benjamin M. Shenker, Middletown. The purpose of the Conference was exploratory in nature and the four areas of discussion concerned the value of information programs on Veterans Medical Care; liaison with state medical societies; relationships with the public and liaison with veterans groups.

The Committee has adopted a policy of retiring its two senior members each year and nominating two new members. The two retiring members this year, Norton Canfield, New Haven and Dr. Joseph M. D'Esopo, New Haven, have served with the Committee ever since its organization in 1946 and have contributed valuably to the Connecticut program.

The plan under which our program operates depends largely on the administrative efficiency of the Hartford Regional VA Office and for this the Committee is indebted to Col. Harry T. Wood, Manager; Dr. Francis J. Ryan, Chief Medical Officer and William H. Feery, Medical Administration Officer.

Without the sincere interest and cooperation of physicians, the program could win little progress and the Committee extends to all participating physicians sincere appreciation for their active support.

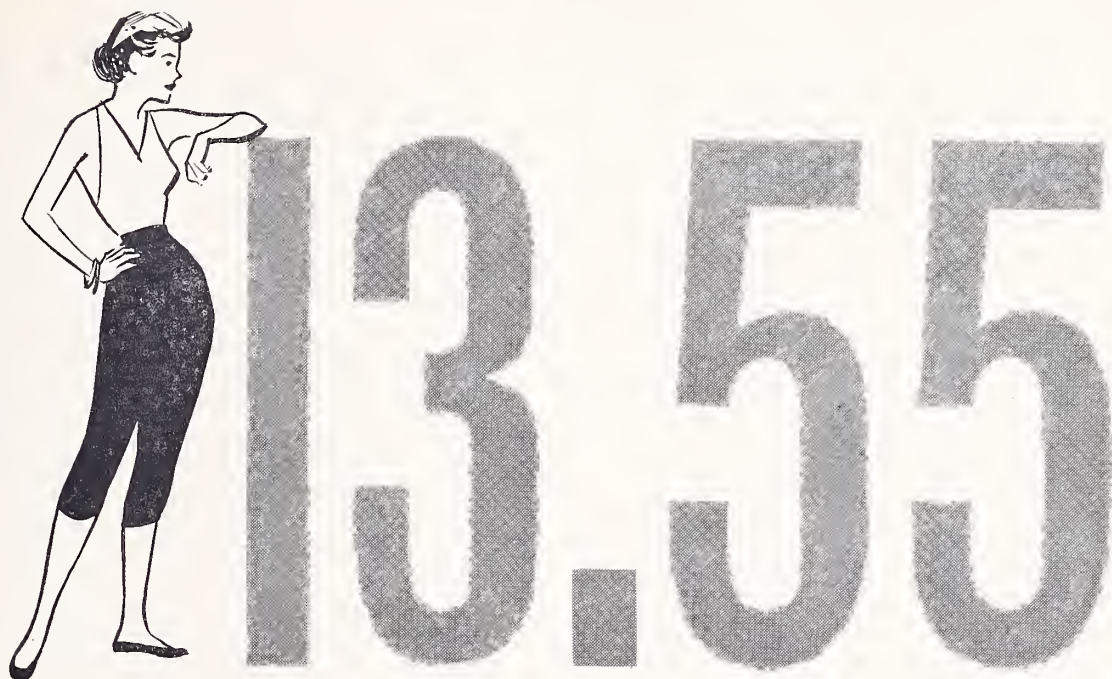
Respectfully submitted,
Samuel B. Rentsch

REPORT OF COMMITTEE ON RURAL MEDICAL SERVICE

Norman H. Gardner, Chairman

Gaert S. Gudernatch	Enos J. O'Connell
James H. Inkster	William H. Pomeroy
Mervyn H. Little	William H. Upson

During the past year the Committee on Rural Medical Service held two meetings. We have continued to carry on the work of exhibiting at the small fairs throughout the state. This has been made more effective because of im-



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Hood Non-Fat Unsalted Cottage Cheese	17.10	0.00	0.00	0.90	21.85	27.3



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proved exhibits and increased experience. The booths have been tended by members of the Woman's Auxiliary.

The committee is deeply grateful to the members of the Woman's Auxiliary who have so unselfishly given their time to the fair exhibits. Without their cooperation the program would have to be abandoned. We feel that such exhibits serve to keep the State Medical Society before the public eye at a time when it is essential.

The Committee wishes also to register its thanks to Mr. James Burch without whose active help so many of our activities would suffer.

Respectfully submitted,
Norman H. Gardner

REPORT OF THE CANCER COORDINATING COMMITTEE

Allan J. Ryan, Chairman

Alfred L. Burgdorf	Ashley W. Oughterson
Matthew H. Griswold	Benjamin R. Reiter
William Mendelsohn	Paul D. Rosahn
Edward J. Ottenheimer	Vincent J. Vinci

Three regular meetings of this committee were called and they were well attended. The business contracted during the year is summarized in the following paragraphs.

1. Medical Advisory Committee.

This committee consented to reappointment and has continued to function in its usual excellent manner.

2. Professional Education.

This committee has again cooperated with the Association of Tumor Clinics to arrange the Annual Cancer Teaching Day Conference. The general practitioners represented only 15% of the total attendance and it may be that some better method may have to be employed to reach this group.

This committee has decided to send a short pertinent message about cancer to all doctors in the State. Perhaps a short medical aphorism sent periodically will stimulate more interest in the cancer problem.

3. Cancer Detection Program in the Doctors' Office.

In cooperation with the county medical societies, a new revised list of doctors has been prepared. This list will be widely distributed by the Connecticut Cancer Society.

4. Early Detection of Lung Cancer.

There is a good deal of interest in this problem and it can be implemented by integrating it with the tuberculosis detection program. Ways and means of doing this are being studied.

5. Utilization of the State Tumor Registry.

The study of cancer of the colon and rectum is almost completed and will represent a most comprehensive one. The next project will be a study of breast cancer and preliminary work has been done.

These problems require much discussion and much time before they can be solved. Your committee is exploring all possibilities to coordinate the efforts in Connecticut toward early diagnosis and treatment of cancer.

Respectfully submitted,
William Mendelsohn

REPORT OF COMMITTEE ON COOPERATION WITH THE YALE UNIVERSITY SCHOOL OF MEDICINE

Benjamin V. White, Chairman

Howard S. Colwell	Walter I. Russell
Daniel Hardenbergh	F. Erwin Tracy
Allan M. Ross	N. William Wawro

The Committee on Cooperation with the Yale University School of Medicine has had no problems referred to it during the past year. A single meeting was held on March 1, 1955, for the discussion of mutual problems. Dr. Lippard reported that there had been much interest in the course on Economics of Medical Practice presented jointly by the Connecticut State Medical Society and the School of Medicine. This course consisted of nine lectures and discussion classes held at four P. M. on successive Thursday afternoons in January, February, and March, 1955. Dr. Ross commented favorably upon the postgraduate course on pulmonary disease offered by the School of Medicine during the past year. It was believed on the basis of this experience that well organized post graduate courses in the future might also be well attended. There were informal discussions centered about internships, residencies, the problems presented by graduates of unapproved foreign medical schools, affiliation of non-teaching hospitals with medical schools, and similar general topics.

The members present at the dinner meeting were of the opinion that the committee was one of great potential value and should be continued even though in this particular year there were no important agenda.

Respectfully submitted,
Benjamin V. White

REPORT OF THE JOINT CONFERENCE WITH THE CONNECTICUT PHARMACEUTICAL ASSOCIATION

Barnett Greenhouse, Chairman

Martin I. Hall	Walter J. Keeefe
Benjamin Katzin	William V. Wener

This Committee has been extended to include a delegation also from the Connecticut State Dental Association, making it a three-way Conference Committee between the physicians, dentists and pharmacists.

Four meetings a year are held and each meeting is over-subscribed. Discussions of mutual interest are carried on amicably, augmenting the friendly relationship which exists between the three organizations.

The subcommittee on Food, Drugs, and Cosmetics meets every two months and continues to serve an important function in its field. The current chairman of this Committee is Dr. Joseph DeVita, V.M.D. and Dr. Harry Fisher of the Connecticut Agricultural Station continues as its able secretary.

Respectfully submitted,
Barnett Greenhouse

REPORT OF THE DELEGATES OF THE COUNCIL OF NEW ENGLAND STATE MEDICAL SOCIETIES

The Annual Meeting of the Council of New England State Medical Societies was held in Boston on April 20, 1955. It was poorly attended because of conflicting meetings. Norman Gardner of East Hampton, Connecticut, member of the Council on Rural Health of the American Medical Association, and Dr. Archbald, director of the Division of the Department of Health of Massachusetts, presented excellent papers on Rural Health in Connecticut.

The president noted that a committee previously appointed to study means of improving the work of the Council had not accomplished its work due to the untimely death of Joseph H. Howard. The chairman appointed the officers for the ensuing year as a committee to undertake the work of the previously appointed committee. The next meeting of the Council is expected to be held in conjunction with the Clinical Session of the American Medical Association in Boston in December of this year.

Respectfully submitted,
Cole B. Gibson
William H. Horton
Oliver L. Stringfield

Heart Association Program

Service, education, and research are combined in the rheumatic fever prophylaxis program of the Connecticut Heart Association and Connecticut Pharmaceutical Association announced to all Connecticut physicians on June 4, 1955.

Approved by the Council of the Connecticut State Medical Society and the Executive Committee of the Connecticut Pharmaceutical Association, the plan will provide every physician with an opportunity to use penicillin for prevention of rheumatic fever at a nominal cost to his patient.

Details of this program have been worked out by a joint committee representing the groups listed above. The supplier of the drug was selected through competitive bidding open to all manufacturers.

Every physician in Connecticut has been supplied with application blanks for this prophylactic penicillin which he may submit for each patient requiring such prophylaxis. Additional application forms may be obtained from local Heart Associations. By return mail the physician will receive a supply of specially printed prescription banks for the individual patient sufficient for a year's supply of penicillin.

The patient may take this prescription to almost any pharmacy in Connecticut, since the cooperation

of the retail pharmacists has been most gratifying. The prescription will be filled on a delayed basis, as only the wholesale druggists are stocking the special package. The wholesale distributor will send the package to the pharmacist with his regular order. The prescription stub and application forms will then be used by the Connecticut Heart Association for a statistical study of this program.

SPECIAL NOTICES

PROGRAM FOR PRESCHOOL INSTITUTE, OAK HILL SCHOOL, HARTFORD

August 28 - September 2, 1955

Sunday, August 28

3:00-5:00 P. M. Open house and tour of school for parents and their families

Monday, August 29

9:00-9:40 A. M. Welcome, History of School—Mr. Johns

9:40-10:20 A. M. Discuss plans for week—Staff

10:20-11:00 A. M. Braille class

1:00-2:00 P. M. Nutrition and eating habits—Mrs. Eloise K. Eckler, chief nutrition consultant, Connecticut State Department of Health

2:00-3:00 P. M. Parent-child relationship (speaker not confirmed yet)

8:00-10:00 P. M. Informal reception and get-together at Mr. Johns' residence

Tuesday, August 30

9:00-9:40 A. M. Children's literature—Mrs. Marjorie Sanders, nursery teacher, Oak Hill School

9:40-10:20 A. M. Toys, playmates, mannerisms—Miss Pace, first grade teacher, Oak Hill School

10:20-11:00 A. M. Braille class

1:00-2:00 P. M. Nursery school and what it offers—Mrs. Sanders

2:00-3:00 P. M.

7:00-10:00 P. M. Recreation program

Wednesday, August 31

9:00-9:40 A. M. Special equipment used in education of blind children—Mrs. Hayes

9:40-10:20 A. M. Later vocations—Mr. Kenneth McCollum, rehabilitation supervisor for the blind, State Board of Education of the blind

10:20-11:00 A. M. Braille class

1:00-2:00 P. M.

2:00-3:00 P. M. Special classes in public schools—Miss Serena Cummings, assistant supervisor in education (blind and partially seeing children), Massachusetts Department of Education

7:00-10:00 P. M. Recreation

Thursday, September 1

9:00-9:40 A. M. Adjustment problems from a parent's

viewpoint—Mrs. Raleigh Dresser, mother of a blind boy enrolled at Oak Hill School

9:40-10:20 A. M. Sleeping habits and toilet training—Mrs. Marjorie Foden, public health nurse, State Board of Education of the Blind

10:20-11:00 A. M. Braille class

1:00-2:00 P. M. Child growth and development (including emotional)—Miss Marian MacDonnell, psychological examiner, Hartford Board of Education; instructor in Department of Education, Hillyer College

2:00-3:00 P. M. The eye and its care—Dr. Henry L. Birge, school ophthalmologist

7:00-10:00 P. M. Recreation

Friday, September 2

9:00-10:00 A. M. General discussion, parents and staff

10:00-11:00 A. M. Resources available in the State—speaker not confirmed yet—someone from State Board of Education

AMA PUBLIC RELATIONS INSTITUTE

Drake Hotel, Chicago

August 31 and September 1, 1955

Subjects to be discussed: Grass Roots Activity in National Legislation; Basic Public Relations Techniques; Medicine in the Magazines; The Individual's Role as a PR Communicator.

INDUSTRIAL HEALTH SYMPOSIUM

Thursday, September 22, 1955

Held under the auspices of the Committee on Industrial Health, Connecticut State Medical Society. Sponsored by The United States Rubber Company, Footwear Division, Naugatuck, Connecticut.

Scientific Sessions

All sessions will be held at the main hospital of the United States Rubber Company, Water Street, Naugatuck. Parking space will be available.

Moderator—Alphonse DellaPietra, M.D., consulting orthopedic surgeon, U. S. Rubber Co., Naugatuck; attending orthopedic surgeon, St. Mary's Hospital, Waterbury

2:00 P. M.

Low-back conditions found on pre-employment physical examination as related to industrial liability

David Bosworth, M.D., attending orthopedic surgeon, St. Luke's, New York Polyclinic and Seaview Hospitals; consultant to Orthopedic Department, University of Vermont

2:45 P. M.

Discussion

3:00 P. M.

Treatment of hip injuries

Frederick R. Thompson, M.D., assistant attending orthopedic surgeon, St. Luke's Hospital; clinical professor of orthopedic surgery, Polyclinic Medical School and Hospital; secretary of the Orthopedic Section of The American Medical Association

3:45 P. M.

Discussion

4:00 P. M.

Secondary repair in severe industrial hand injuries

William Littler, M.D., associate attending surgeon, Roosevelt Hospital, New York; Plastic Reconstructive Surgery; consultant to the Surgeon General, Valley Forge General Hospital

4:45 P. M.

Discussion

Moderator—Richard J. Hinchey, B.S., M.D., M.P.H., assistant medical director, United States Rubber

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5:00 P. M.

Hematic and neoplastic health hazards in the rubber industry

William Hueper, M.D., chief of Environmental Cancer Section, National Institute of Health, Bethesda, Maryland

5:45-6:00 P. M.

Discussion

PROGRAM COMMITTEE

Andrew J. Jackson, M.D., medical director; Richard J. Hinchey, M.D., assistant medical director; Alphonse Della Pietro, M.D., consultant in orthopedics; W. E. Bittle, factory manager; T. Rex Behrman, industrial relations manager; Andrew J. Jackson, Jr., hospital administrator.

MASSACHUSETTS ACADEMY OF GENERAL PRACTICE ANNUAL MEETING

September 24, 1955

The Massachusetts Academy of General Practice will hold its annual meeting on Saturday, September 24, 1955.

Because of the scope of the program, the Grand Ballroom of the Hotel Statler, Boston, Massachusetts, has been reserved for this purpose.

The morning session will be devoted to a series of down-to-earth papers on subjects which the doctor can use in his everyday practice.

The speakers have been selected not only for their wide experience, but also for their ability to communicate their information on a practical level. A real clinical treat is in store for the afternoon session. The Surgeon General (Department of the Army) and his staff will present a symposium on the treatment of mass casualties.

COURSE IN POSTGRADUATE GASTROENTEROLOGY

The American College of Gastroenterology announces that its annual course in Postgraduate gastroenterology will be given at The Shoreland in Chicago, Illinois, on October 27, 28, 29, 1955.

The course will again be under the direction of cochairmanship of Dr. Owen H. Wangensteen, professor of surgery of the University of Minnesota Medical School, who will serve as surgical coordinator and Dr. I. Snapper, director of medical education, Beth-el Hospital, Brooklyn, N. Y., who will serve as medical coordinator. Drs. Wangensteen and Snapper will be assisted by a distinguished faculty selected from the medical schools.

The subject matter to be covered in the course, from a medical as well as surgical viewpoint, will cover, essentially, the advances in diagnosis and treatment of gastrointestinal diseases and a comprehensive discussion of diseases

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For further information and enrollment write to the American College of Gastroenterology, Department P.G., 33 West 60th Street, New York 23, N. Y.

62nd ANNUAL CONVENTION ASSOCIATION OF MILITARY SURGEONS OF THE UNITED STATES

To be held at Hotel Statler, Washington, D. C., November 7, 8 and 9, 1955.

THE AMERICAN DERMATOLOGICAL ASSOCIATION, INC.

Annual Prize Essay Contest

The American Dermatological Association is again offering a series of prizes for the best essays submitted for original work, not previously published, relative to some fundamental aspect of dermatology or syphilology. The purpose of this contest is to stimulate investigators to original work in these fields. Cash prizes will be awarded as follows: Five hundred dollars, four hundred dollars, three hundred dollars and two hundred dollars for first, second, third and fourth place, respectively.

Manuscripts typed in English with double spacing and ample margins as for publication, together with illustrations, charts and tablets, all of which must be in triplicate, are to be submitted not later than November 15, 1955.

The manuscripts should be sent to Dr. J. Lamar Callaway, secretary, American Dermatological Association, Duke Hospital, Durham, North Carolina. Those which are incomplete in any of the above respects will not be considered. Manuscripts should be limited to ten thousand words or less and the time of presentation of prize essay shall not exceed thirty minutes. In order to aid fair judgment, papers should be submitted under a nom de plume with no information anywhere in the paper as to the institution or clinic where the work was done. Along with the paper by "John Smith" for example, a plain sealed envelope bearing the nom de plume plus the full name and address of the author is also submitted. Only after all of the papers have been judged and returned to the chairman are the sealed envelopes opened and the winners known.

Competition in this prize contest is open to scientists generally, not necessarily to physicians.

THIRD STANDARD NOMENCLATURE INSTITUTE

The third series of three-day classes covering the practical applications of the Standard Nomenclature of Diseases and Operations in the hospital or medical clinic will be conducted October 10, 11, 12 at AMA Headquarters, Chicago. Included in the short course will be lectures on the theory, basic principles and installation of the Nomenclature relating to the topographic section. Practice in coding also will be offered. Lectures on theory will be given by Adaline C. Hayden, C.R.L., associated editor of *Standard Nomenclature*, AMA, and on anatomy by Edward T. Thompson, M.D.,

chief of programs operations, hospital facilities, U. S. Public Health Service, Washington, D. C. Classes will be restricted to the first 100 registrants. Applications should be sent immediately to Mrs. Hayden at AMA Headquarters.

OUR NEIGHBORS

Massachusetts

Chester S. Keefer, for 15 years Wade Professor of Medicine at Boston University and physician-in-chief of clinical research in preventive medicine at the Massachusetts Memorial Hospitals, has been appointed director of Boston University School of Medicine. Dr. Keefer succeeds Dr. James M. Faulkner who has moved over to the Massachusetts Institute as medical director.

NEWS

from County Associations

Fairfield

Carl J. Gade, chief of the orthopedic department at St. Vincent's Hospital, Bridgeport, died in that hospital on June 19 after a very brief illness. Dr. Gade was formerly an instructor at the Yale University School of Medicine and had practised in Bridgeport for 36 years.

Robert J. Lynch, who had practised medicine in Bridgeport for 57 years, died July 7 in the Bridgeport Hospital at the age of 82 years. In 1952 the State Medical Society honored Dr. Lynch at the completion of 50 years of membership.

A Committee on the American Medical Education Foundation, approved at the semiannual meeting of the Fairfield County Medical Association, has been appointed consisting of John W. Jovell, Danbury, Newell W. Giles, Stamford, and Robert A. Northrop, Norwalk. Appointments were made by President Nathaniel B. Selleck, Danbury.

Sister Margaret has been elevated to the post of administrator of St. Vincent's Hospital, Bridgeport, succeeding Sister Marie. The latter has been advised to take a prolonged rest because of ill health. Sister Margaret had been serving as assistant administrator.

Appointed recently by President Selleck to a vacancy on the Public Relations Committee of the Fairfield County Medical Association was Halsey G. Bullen, Stamford.

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Bumbalo, T. S., Gustina, F. J.,
and Oleksiak, R. E.:
J. Pediat. 44:386, 1954.

White, R. H. R., and
Standen, O. D.:
Brit. M. J. 2:755, 1953.

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Brown, H. W.:
J. Pediat. 45:419, 1954

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Members of the Fairfield County Medical Golf Association will engage in their third round matches this month on August 24 at the Mill River Country Club, Stratford.

Hartford

One of Hartford's oldest and most colorful surgeons, Edward R. Lampson, died suddenly at the Hartford Hospital on June 24. Dr. Lampson had celebrated his 87th birthday only ten days before. He was a member of the surgical staff of the Hartford Hospital from 1903 until his retirement in 1937.

Francis J. Braceland of Hartford is the author of "Emotional Problems Among Executives" published in the May, 1955 issue of *Medical Annals of the District of Columbia*.

Sidney E. Eisenberg of New Britain has been appointed assistant clinical professor of medicine at Yale University School of Medicine.

Carl S. Hellijas was elected president of the Connecticut State Society of Anesthesiologists at the recent annual meeting of the Society.

George D. Dorian of New Britain, now studying at Warm Springs, Georgia, has been awarded a \$500

scholarship by the United Cerebral Palsy Association of New Britain to aid him in his study of neuromuscular diseases.

St. Francis Hospital, Hartford, has established a joint committee for the improvement of the care of the patient. Representatives from the governing board, the medical staff, administration, nursing service and nursing education are included in the committee membership. Dillon Reidy, M.D., chairman of the committee, is a member of the Connecticut Joint Commission for Improvement of Care of the Patient.

Middlesex

John Korab was re-elected as president of the Middlesex Chapter of the American Heart Association.

Three new interns began their duties at Middlesex Memorial Hospital on July 1. They are Mary Lou Howbert, a graduate of the medical school of the University of Kansas; James Howbert, also from the University of Kansas; and Felix Sheehan from Queens University of Belfast, Belfast, Northern Ireland.

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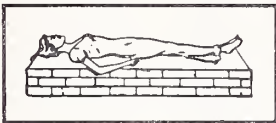
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New Haven

Rocco Bove, health officer and school physician for the town of East Haven, died suddenly on June 12 at his home in East Haven at the age of 57. Dr. Bove had served as town health officer for ten years and also carried on a private practice in New Haven and East Haven.

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NEW BOOKS IN REVIEW

THE NEW YEAR BOOK OF RADIOLOGY, 1954-55 Series. Edited by John Floyd Holt, M.D., and Fred Jenner Hodges, M.D., University of Michigan; Harlod W. Jacox, M.D., and Morton M. Kilgerman, M.D., Columbia University. Chicago, Illinois: The Year Book Publishers, Inc. 432 pp., 348 illustrations. \$9.

Reviewed by **SIDNEY L. CRAMER**

Following the format of previous years, the diagnostic section of this Year Book was edited again by Drs. Hodges and Holt while the therapy division had a new editor in Dr. Kilgerman, working with Dr. Jacox.

On Sabbatical leave, Dr. Hodges spent some time observing the specialty of radiology as practiced in Sweden, and in a searching, special article compared American and Scandinavian methods of practice and philosophy. It was an enlightening report and explained in some respects the reason for the excellent radiologic work which emanates from Sweden.

Several papers dealt with technical developments, important amongst which were studies of the mediastinum and other air-bearing structures by supervoltage techniques. Even the efficiency of red goggles for adaptation was evaluated with the startling conclusion that they were useless in bright sunlight.

Amongst the innumerable articles related to diagnosis were examples of the unusual and bizarre, such as hydatid disease, metaphyseal fractures in children, chest findings in "collagen" diseases, amyloidosis of the stomach, and leptospirosis of the lung. Several papers on angiocardiology were repetitious and added but little to that already reported previously. Similarly there were a few reminders of the difficulties of differentiating benign from malignant lesions of the prepyloric stomach; that peptic ulcer may occur in children; and that amebiasis may simulate carcinoma in the colon.

However, what made this edition worthwhile was the excellent review of several papers on that perplexing area of the gastrointestinal tract, namely, the lower esophagus. The anatomy and physiology were reviewed and true pathology was separated from false impressions.

Also the papers on oral cholangiography were important

since these were of early series of cases upon which certain diagnostic criteria were established and since proven to be in error.

Of much practical value was the inclusion of reviews on several orthopedic and pulmonary subjects.

In their introduction to the therapy section the authors pointed to the direction which experimentation would take in the next few years, namely, to find sensitizers and chemical augmenters to be used in conjunction with new high energy equipment to be developed. Most of the papers which were reviewed concerned the personal experiences of groups and individuals using a multitude of new mechanical devices and radiation sources, all striving for better survival and cure rates.


In their analogy between radiology and the growth of plants and trees as found in Nature, the authors stated that in this Year Book they attempted to retain what they be-

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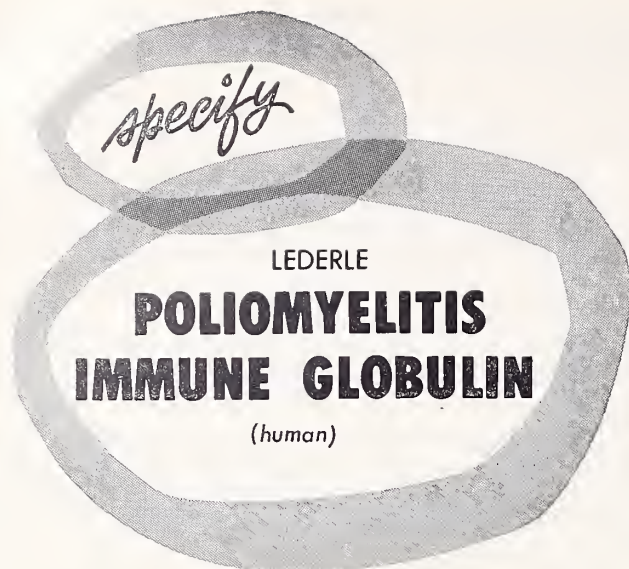
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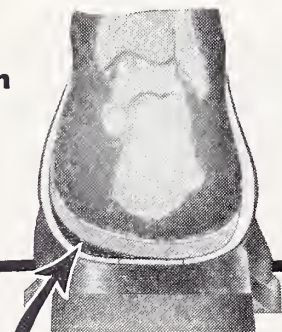
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lieved to be the most promising and vigorous of the annual crop. It would seem that their judgment was excellent, since the present edition was most interesting and useful.

YEARBOOK OF PSYCHOANALYSIS, Vol. X. Sandor Lorand, M.D., Managing Editor. New York: International Universities Press, Inc. 1955. 277 pp. \$7.50.

Reviewed by RICHARD KARPE

Twenty-one papers published in 1953 were selected for this Yearbook. Three of those papers are directly concerned with Freud and his writings. Bernfeld's paper discusses the three years in Freud's life in which he was mainly interested in the investigation of cocaine. That was about ten years before Freud's self analysis. Bernfeld analyzes here Freud's errors and corrects, somewhat, the report that Freud gave about it. Muriel Gardiner reports in a fascinating way her experiences with the "wolf man." This was a patient which was described by Freud in his paper, "An Infantile Neurosis." Gardiner's report can serve as a follow-up on one of Freud's important case studies. Katan studies a phase in another of Freud's case studies, the well known Schreber case, who still is a topic of controversy almost half a century after its publication.

Of clinical interest is Bak's paper on fetishism who assumes that the intensity of castration fears depends on the inner wish for an identity with the mother, modifying Freud's exclusive focus on the external danger. Easily understandable for the nonanalytic reader is Stein's "Premonition as Defense," Reider's "A Type of Transference to Institutions," and Knapp's paper, "The Ear Listening and Hearing."

Of more general cultural interest are papers like Barrett's, "Mark Twain's Osteopathic Cure," Loewenberg's discussion of Manuel Kant's self analysis, Procter-Gregg's discussion of a theme in Gilbert and Sullivan's operetta, "Ruddigore," Devereux's paper, "Why Oedipus Killed Laius," Roheim's "The Language of Words." Three papers discuss the dream and the dream's screen, a concept introduced by Bertram Lewin.

Several papers can be understood only by the expert who has a detailed knowledge of psychoanalytic research and literature. To these, the very specialized, but very fruitful studies, belong: Reich's "Narcissistic Object Choice in Women," Sterba's "Clinical and Therapeutic Aspects of Character Resistance," Gero's "Defenses in Symptom Formation," Reider's "Reconstruction and Screen Function," Feldman's "A Syndrome Indicative of Repressed Oral Aggression," and Winnicott's "Transitional Objects and Transitional Phenomena." This book, as its forerunners, can serve as a substitute for the reading of the psychoanalytic journals.

BICKHAM-CALLANDER SURGERY OF THE ALIMENTARY TRACT. By Richard T. Shackelford, M.D., Assistant Professor of Surgery, Johns Hopkins University School of Medicine, Baltimore, Maryland. Philadelphia: W. B. Saunders Co. 1955. Three volumes; 2,575 pp.; 1,705 figures.

Reviewed by JAMES H. P. GARNETT

This is a book on surgical technic which every general surgeon will wish to own, and which every hospital library should own. Unquestionably it will become the standard reference in its field.

In 1924 Bickham published his great text on operative surgery, presenting in six volumes the technics of general and special surgery. This monumental work described and illustrated every operative procedure that was then being performed in the hospitals of the world. Surgeons of that era will remember its value. Thirty years of surgical progress have, however, made it obsolete. Recent emphasis has been on other aspects of surgery than technic, and so a need exists to carry Bickham's concept forward and present in detail the procedures performed today in the best hospitals and clinics of this country. Dr. Shackelford has performed that service, and he has done it well. His work represents six years of writing, editing, and, most important, evaluating. It most definitely is original work, and is not a rehash of old material. To quote from the preface: "The great concept of this work and its basic outline are Bickham's; many improvements and additions are Callander's; the writing, the evaluations, and the deficiencies therein are mine."

The work is presented in 2,575 pages divided into three volumes. There are 1,705 excellent illustrations. Authorities in their various fields are frequently quoted. Complete sections are taken from Sweet's Thoracic Surgery, and from Gross' Surgery of Infancy and Childhood. Lahey Clinic and Mayo Clinic publications are prominently used. Excerpts are also reprinted from Bacon's Anus, Rectum, and Sigmoid Colon, and from TeLinde's Operative Gynecology. Some of the anatomical text and plates are taken from Anson's work. All of the procedures used in gastrointestinal surgery today are presented, illustrated, discussed and criticized.

Volume I consists of 862 pages divided into Chapter 1—Esophagus, Chapter 2—Stomach and Duodenum, Chapter

3—Liver, Chapter 4—Gallbladder and Extrahepatic Biliary Ducts. The first chapter is organized under anatomy, physiology, anesthesia, incisions, special principles of esophageal surgery, technics of investigation, and finally, specific procedures and operations. Preoperative and postoperative care are thoroughly discussed. Each procedure is discussed from the point of view of indications and analysis of results. The author freely criticizes questionable procedures, and usually indicates personal preference where choice is possible. This general format is closely followed throughout all three volumes and makes the work extremely well organized and of particular value in its intended role: that of reference. Among the more recent procedures fully covered in Volume I are the use of Berman's plastic esophageal tubes; primary ligation of bleeding esophageal varices; partial hepatectomy; the gastrectomy versus vagotomy controversy; reconstruction of the common duct; the surgery of portal hypertension.

Volume II covers Pancreas, Spleen, Small intestine, Peritoneum omenta and mesentery, and Colon. Cattell's results following pancreatic resection are thoroughly discussed. Ulcerative colitis and malignant disease of the colon are fully covered. The section on the spleen is extremely well presented.

Volume III presents Anorectal tract, Excisions of the rectum, Hernia of the gastrointestinal tract, Incisions. The bibliography is excellent, and cross references make it easy to look up any point.

This book occupies a place in surgery similar to that previously enjoyed by Bockus' Gastroenterology in medicine. It is completely modern and up to the minute, and yet,

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in general, is conservative where serious controversy exists. It is encyclopedic in completeness. It is beautifully illustrated. Dr. Shackelford is to be congratulated.

PERINATAL MORTALITY IN NEW YORK CITY. A Study of 955 Deaths by The Subcommittee on Neonatal Mortality, Committee on Public Health Relations, The New York Academy of Medicine. Analyzed and reported by Schuyler G. Kohl, M.S., M.D., DR.P.H. Cambridge, Mass.: Harvard University Press. 1955. 112 pp. \$2.50.

Reviewed by STANLEY B. WELD

This volume is the result of an outstanding piece of research done by a committee of nine obstetricians, nine pediatricians and three pathologists under the direction of Schuyler G. Kohl, associate professor of obstetrics and gynecology in the State University of New York, College of Medicine in Brooklyn. The study covered the records from 104 municipal, voluntary and proprietary hospitals in New York City for 1950 and a few months of 1951. It was financed by five foundations supplying a total of \$50,000.

The purpose of the study was to delve into the preventability, responsibility, causes of death, and related clinical data furnished by these 955 cases. Particularly the study sought to learn about the prenatal care, toxemia, preventability, analgesia, anesthesia, type of medical attendant, evaluation of pediatric care, all of which were not obtainable for the entire city experience, or were not really reported.

It was discovered that 35 per cent of the perinatal deaths were preventable. For all the deaths studied, both prevent-

able and nonpreventable, the responsibility rate present in over one-half the cases was unavoidable disaster. Errors in medical judgment accounted for almost one-third, unsatisfactory pediatric care for a little over one-fourth, errors in medical technique for almost one-fourth, and faulty prenatal care for slightly over one-fifth. In many instances more than one factor was assigned to a case. The house staffs showed the highest preventability rate and the obstetricians the lowest. The lowest rate of preventability was found in the voluntary teaching hospitals. The preventability rates were consistently higher for deaths in ward service cases than for deaths in private cases.

A general anesthetic had been used in over 48 per cent of the deaths of premature infants, pointing to the advisability of using conduction anesthesia in this group. Another striking finding was the fact that the preventability rate for infants dying during labor was 35 per cent for the premature and 62 per cent for the mature infants. The clinical causes of death were found to give the best information for the entire series of 955 deaths, however, the value of autopsies was emphasized.

The reporter made several suggestions for similar studies which may be conducted in the future.

Inasmuch as this problem is interesting to obstetricians, pediatricians, and anesthesiologists in many hospitals, this study should create widespread interest. The book is copiously documented with tables and carries appendices giving the various forms used and a specimen correlation table, as well as several references. Dr. Kohl and his fellow workers are to be congratulated on an excellent study.

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The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. XIX

SEPTEMBER, 1955

No. 9

THIRTIETH CONNECTICUT CLINICAL CONGRESS
of the
CONNECTICUT STATE MEDICAL SOCIETY
and the
YALE UNIVERSITY SCHOOL OF MEDICINE

YALE-NEW HAVEN MEDICAL CENTER
310 CEDAR STREET, NEW HAVEN

September 14, 15, 1955

GENERAL INFORMATION

REGISTRATION FEE

The registration fee of \$3 provides for admission to all sessions of the Congress.

Hospital residents, interns, and medical students will be admitted to all sessions without charge, if a statement of their position, signed by an official of the hospital or medical school, is presented at the special registration desk at 310 Cedar Street.

MEETING PLACE

All of the sessions will be held in Brady Auditorium and Fitkin Amphitheater at the School of Medicine and New Haven Hospital. Two sessions will be held simultaneously giving a broad selection of topics.

TELEPHONE

Telephone messages will be received at New Haven LOcust 2-1161.

LUNCHEON

Cafeteria luncheons will be available.

PARKING

There are public parking areas near the hospital and metered curb parking. Automobile stickers will be provided for all registrants.

PROGRAM

THIRTIETH CONNECTICUT CLINICAL CONGRESS

WEDNESDAY, SEPTEMBER 14, 1955

9:30 REGISTRATION

BRADY AUDITORIUM

H. M. Marvin, *New Haven, presiding*

10:00 CLINICAL ASPECTS OF DISORDERS OF COAGULATION

Mario Stefanini, *Brighton, Massachusetts; Associate Professor of Medicine, Tufts College Medical School; Director of Research and Hematologist, St. Elizabeth's Hospital, Brighton*

11:00 ANTICOAGULANTS

11:00 William T. Foley, *New York City; Chief of Vascular Clinic, New York Hospital; Assistant Professor of Clinical Medicine, Cornell University Medical College*

11:30 Henry I. Russek, *Staten Island, New York; Consultant in Cardiovascular Research, USPHS Hospital, Staten Island; Instructor in Medicine, New York Medical College*

12:00 Discussion

12:30 LUNCHEON

Frederick W. Finn, *Greenwich, presiding*

2:00 HYPOPHYSECTOMY FOR BREAST CANCER

Bronson S. Ray, *New York City; Chief, Department of Neurosurgery, New York Hospital; Professor of Clinical Surgery, Cornell University Medical College*

2:45 CHEMOTHERAPY OF NEOPLASTIC DISEASE: ITS RELATIONSHIP TO SURGERY

Joseph H. Burchenal, *New York City; Professor of Medicine, Sloan-Kettering Division, Cornell University Medical College; Attending Physician and Chief, Chemotherapy Service, Memorial Hospital*

3:30 CHANGING CONCEPTS OF CANCER SURGERY

J. Englebert Dunphy, *Boston, Massachusetts; Professor of Surgery, Harvard Medical School; Director of Fifth Surgical Service and Sears Surgical Laboratory, Boston City Hospital*

4:15 Adjournment

The Connecticut Chapter of the American Academy of Pediatrics will hold a social hour and dinner, beginning at 5:30 P. M., at the New Haven Medical Association, 364 Whitney Avenue, New Haven, on Wednesday, September 14. Annual business meeting to follow.

Members of the Hezekiah Beardsley Pediatric Club are cordially invited to be present at the social hour and dinner. Reservations for dinner must be made in advance by mailing check for \$4 to dinner chairman: Edward T. Wakeman, M.D., 240 Bradley Street, New Haven.

WEDNESDAY, SEPTEMBER 14, 1955

9:30 REGISTRATION

FITKIN AMPHITHEATER

Barnett Greenhouse, *New Haven, presiding*

10:00 USE OF VARIOUS TYPES OF INSULIN

David Hurwitz, *Cambridge, Massachusetts; Assistant Clinical Professor of Medicine, Harvard Medical School; Chief of Diabetic Service, Boston City Hospital; Chief of Division of Medicine, Mount Auburn Hospital, Cambridge*

10:45 USE OF FRUCTOSE IN TREATMENT OF DIABETIC ACIDOSIS

Max Miller, *Cleveland, Ohio; Associate Professor of Medicine, Western Reserve University School of Medicine; Associate Physician, University Hospitals of Cleveland*

Roy N. Barnett, *Norwalk, presiding*

11:30 CLINICOPATHOLOGICAL CONFERENCE

Benjamin Castleman, *Boston, Massachusetts; Chief, Department of Pathology, Massachusetts General Hospital; Clinical Professor of Pathology, Harvard Medical School*

Discussants: Dudley B. Blossom, *Greenwich*
Max Taffel, *New Haven*

12:30 LUNCHEON

2:00 PANEL ON LOW BACK PAIN

Ettore F. Carniglia, *Hartford, Moderator*

Preston N. Barton, *Meriden, Connecticut; Lecturer, Occupational Medicine, Yale University School of Medicine*

Charles O. Bechtol, *New Haven, Connecticut; Chief, Division Orthopedic Surgery, Yale University School of Medicine; Chief, Orthopedic Service, Grace-New Haven Community Hospital*

Louis Linn, *New York City; Assistant Attending Psychiatrist, Mt. Sinai Hospital, New York*

Morton Marks, *New York City; Assistant Professor, Clinical Neurology, New York University College of Medicine; Assistant Attending Neurologist, University Hospital*

3:15 PANEL ON HEADACHE

Gilbert H. Glaser, *New Haven, Moderator*

Arnold P. Friedman, *New York City; Associate Professor Clinical Neurology, Columbia University College of Physicians and Surgeons; Director, Headache Unit, Montefiore Hospital*

Theodore Lidz, *New Haven, Connecticut; Professor of Psychiatry, Yale University School of Medicine; Psychiatrist-in-Chief, University Division, Grace-New Haven Hospital*

4:30 Adjournment

THURSDAY, SEPTEMBER 15, 1955

9:30 REGISTRATION

FITKIN AMPHITHEATER

Hugh L. Dwyer, *New Haven, presiding*

10:00 INTRACTABLE HEART FAILURE: ITS MANAGEMENT

Hugh Luckey, *New York City; Dean, Cornell University Medical College; Attending Physician, New York Hospital*

10:45 MANAGEMENT OF PATIENTS WITH ARTERIAL DISEASE

F. A. Simeone, *Cleveland, Ohio; Professor of Surgery, Western Reserve University School of Medicine; Surgeon-in-Chief, City Hospital of Cleveland*Ralph E. Kendall, *Hartford, presiding*

11:30 CLINICOPATHOLOGICAL CONFERENCE

H. E. MacMahon, *Boston, Massachusetts; Professor of Pathology, Tufts University School of Medicine; Pathologist-in-Chief, New England Medical Center*Discussants: John C. Leonard, *Hartford*Frederick B. Hartman, *New London*

12:30 LUNCHEON

William H. Curley, Jr., *Bridgeport, presiding*

2:00 COMPLICATIONS OF BILIARY TRACT SURGERY AND THEIR TREATMENT

Charles B. Ripstein, *Bronx, New York; Professor of Surgery, Albert Einstein College of Medicine, New York; Chief of Surgery, Bronx Municipal Hospital Center*

3:00 INDICATIONS FOR EMERGENCY SURGERY IN BILIARY TRACT DISEASE

3:00 Henry Doubilet, *New York City; Associate Professor of Surgery, New York University College of Medicine; Visiting Surgeon, Bellevue Hospital (Third Division)*3:30 Samuel J. Stabins, *Rochester, New York; Associate Professor of Surgery, University of Rochester School of Medicine and Dentistry; Surgeon-in-Chief, Genesee Hospital, Rochester*

4:00 PANEL DISCUSSION—BILIARY TRACT SURGERY

William H. Curley, Jr., *Bridgeport, Moderator*Panel: Charles B. Ripstein, *Bronx, New York*Henry Doubilet, *New York City*Samuel J. Stabins, *Rochester, New York*

4:30 Adjournment

THURSDAY, SEPTEMBER 15, 1955

9:30 REGISTRATION

BRADY AUDITORIUM

10:00 PANEL ON INFECTIOUS HEPATITIS

John R. Paul, *New Haven, Moderator*

ROLE OF CHRONIC CASE AND BLOOD DONORS

John R. Neefe, *Philadelphia, Pennsylvania; Associate in Medicine, University of Pennsylvania School of Medicine; Senior Ward Physician, Hospital of the University of Pennsylvania*

EPIDEMIOLOGY AND CONTROL

Joseph Stokes, Jr., *Philadelphia, Pennsylvania; Professor of Pediatrics, University of Pennsylvania School of Medicine; Physician-in-Chief, Children's Hospital of Philadelphia*

11:15 PANEL ON IMMUNIZATION AGAINST POLIOMYELITIS

Dorothy M. Horstmann, *New Haven, Moderator*

Joseph L. Melnick, *PH.D., New Haven; Professor of Epidemiology, Yale University School of Medicine*

Hilary Koprowski, *Pearl River, New York; Research Division, Lederle Laboratories Division, American Cyanamid Company; Chairman, Section of Biology, New York Academy of Medicine*

12:30 LUNCHEON

2:00 PANEL ON DRUG THERAPY IN HYPERTENSION

C. Louis Fincke, *Stamford, Moderator*

Robert Sterling Palmer, *Boston, Massachusetts; Physician, Massachusetts General Hospital*
William A. Jeffers, *Philadelphia, Pennsylvania; Associate Professor of Medicine, University of Pennsylvania School of Medicine; Chief of Hypertension Section, Hospital of the University of Pennsylvania*

3:15 PANEL ON NEW TRANQUILIZING DRUGS

John Donnelly, *Hartford, Moderator*

Paul H. Hoch, *New York City; Commissioner of Mental Hygiene, State of New York; Associate Professor of Clinical Psychiatry, Columbia University College of Physicians and Surgeons*

Nathan S. Kline, *New York City; Research Associate, Department of Psychiatry, Columbia University College of Physicians and Surgeons; Director of Research, Rockland State Hospital, Orangeburg, New York*

4:30 Adjournment

HOW DANGEROUS ARE THYROID NODULES?

JOSEPH E. SOKAL, M.D., *New Haven*

THE statistical correlation between nodular goiter and thyroid cancer was emphasized by Wegelin in a classic review in 1928.¹ This association has been supported by many studies since then, both in goitrous and in nongoitrous areas. A history of pre-existent goiter is obtained in about one-half to three-quarters of all cases of thyroid cancer. Thus, if the term "pre-malignant" is used in a statistical sense, it is proper to refer to nodular goiter as a "pre-malignant" lesion. It should be remembered, however, that this does not necessarily indicate any sort of cause and effect relationship.

Many authorities have recommended thyroidectomy in all cases of nodular goiter as a desirable cancer prophylactic measure. Others have presented strong arguments against routine prophylactic thyroidectomy.² There has been a great deal of controversy over the frequency of thyroid cancer, and over the alleged discrepancy between various types of statistics on this subject.³ On the one hand, it has been pointed out that thyroid cancer may be seen at autopsy only once in five years at relatively large institutions.⁴ On the other hand, many surgical papers are cited as evidence that from 5 to 15 per cent of nontoxic nodular goiters are malignant.

The physician who discovers an asymptomatic nodular goiter in the course of a physical examination would like to know the answers to three questions:

"How great is the danger that this goiter is, or will become, malignant?"

"Can I differentiate clinically between goiters that are benign and those that might be malignant?"

"If thyroidectomy is performed now, will the risk of thyroid cancer be eliminated?"

The primary aim of this review is to answer the first question. Evidence bearing on the second question will also be presented. I will not attempt the third at this time.

In order to answer our first question, we must calculate from the available data the value of the fraction

$$\frac{\text{malignant nodular goiter}}{\text{all nodular goiter}}$$

The Author. *Associate Chief of Medicine, Roswell Park Memorial Institute, Buffalo, N. Y.*

SUMMARY

All available statistics on the incidence of thyroid cancer are in good agreement. It is a relatively rare disease, representing about one-half per cent of all cancer. In a typical community of one million, there would be twenty-five patients with thyroid cancer. One new case would be diagnosed monthly. There would be six deaths per year from thyroid cancer. One or two of these would come to autopsy.

The risk of cancer in nontoxic nodular goiter is small. Its frequency at any particular time among unselected nontoxic nodular goiters is probably less than 0.2 per cent. The cumulative life-time risk of thyroid cancer for a patient with nontoxic nodular goiter is probably less than 1 per cent.

The risk of cancer in nodular goiter is approximately the same for men and women. Both nodular goiter and thyroid cancer are more common among women.

Clinical differentiation between uninodular and multinodular goiters is of little value, insofar as assessing the risk of malignancy is concerned.

No definitive studies of the efficiency of preoperative selection in nontoxic nodular goiter have been reported. However, the evidence at hand suggests that at many medical centers benign goiters are distinguished from possibly malignant ones with considerable accuracy.

It is important to realize that the surgical statistics usually quoted on this subject do not give us this figure.⁵ Such data tell us what percentage of goiters operated upon at a particular institution were malignant. However, these figures do not apply to the much larger number of goiters which are never removed. This difference between the incidence of malignancy among goiters which are operated upon and those which are not, constitutes, in part, an answer to our second question.

*From the Department of Internal Medicine, Yale University School of Medicine, New Haven, Conn.
Assisted in part by an institutional research grant from the American Cancer Society*

FREQUENCY OF THYROID CANCER

In comparing different types of statistics, one must make sure that figures are expressed in comparable terms. Failure to do this is responsible for most of the confusion and disagreement over the incidence of thyroid cancer. For example, post-mortem examination is performed in no more than 10 per cent of deaths in this country. The fact that most cases of thyroid cancer do not come to autopsy in no way invalidates autopsy statistics; most cases of any disease do not come to autopsy! It means simply that we must consider autopsy statistics on thyroid cancer in reference to other autopsy statistics, not to death figures.

When statistics from a number of sources in this country and in Europe were compared, and the frequency of thyroid cancer in each case expressed in the same units (as a percentage of all cancer), very good agreement was found among autopsy statistics, clinical data of various sorts, and mortality figures.³ It was found that thyroid cancer represented slightly more than 0.5 per cent of clinical cancer and accounted for slightly less than 0.5 per cent of deaths from cancer. This means that in a typical community of 1,000,000 there are 25 patients living with thyroid cancer. One new case appears monthly. There are six deaths per year from thyroid cancer.

A somewhat complex calculation was next undertaken, using surgical statistics from eighteen major centers in the United States.⁵ This resulted in a figure sufficiently close to the above to be considered confirmatory. Table I presents the results of these two studies.

TABLE I
FREQUENCY OF THYROID CANCER, AS A PERCENTAGE OF ALL CANCER

TYPE OF DATA USED FOR CALCULATIONS	FREQUENCY OF THYROID CANCER	
	RANGE PER CENT	MEAN PER CENT
Autopsy statistics	0-1.3	0.47
Mortality statistics	0.4-0.6	0.41
Clinical cancer surveys	0.3-0.8	0.56
Surgical statistics	0.2-2.3	0.96

FREQUENCY OF NODULAR GOITER

There is considerable geographic variation in the incidence of nodular goiter, but it is not rare anywhere. Reports based upon examination of thyroid glands at autopsy give considerably higher figures than are noted clinically. This difference is due largely to two factors. Most of the clinical figures are based upon physical examinations in which the thyroid gland received only casual attention. In many cases these examinations were performed by physicians who were not skilled in searching for thyroid nodules. Under these circumstances many detectable nodules are not found. Also autopsy examinations reveal nodules deep in the substance of the thyroid, or on its posterior aspect, which would not be detected even by skilled examiners. Obviously the autopsy statistics are more accurate, although they are not entirely free from selective factors. Table II gives some figures for the frequency of nodular goiter. The data of Schlesinger *et al.* seem suitable for use as representative of the United States as a whole. They are derived from a non-goitrous community, but the sample includes some individuals who were born in goitrous areas. Nodules were counted only if the autopsy protocol stated they were at least 1 cm. in diameter; if they were smaller, or the size was not stated, the gland was listed as not nodular. The only criticism of Schlesinger's figures is that they are not based on consecutive autopsies. The sample consists of 1,371 autopsies in which the thyroid was examined, out of 2,185 autopsies in all. If there were no nodules among the glands not examined (a most unlikely assumption), the corrected figures would be one-third lower. Such figures would certainly be a conservative estimate of the frequency of nodular goiter in our population. The prevalence of nodular goiter, on this reduced basis, would be about 3.7 per cent for a standardized population. This figure, 37,000 per million of population, may be compared with the prevalence of diagnosed thyroid cancer—approximately 25 per million of population. It is obvious that, even if we assume there are several occult thyroid cancers for every diagnosed case, over 99 per cent of nodular goiters must be benign.

TABLE II
FREQUENCY OF NODULAR GOITER

TYPE OF DATA AND REFERENCE	FREQUENCY OF NODULAR GOITER CORRECTED TO STANDARD	
	FOUND PER CENT	POPULATION PER CENT
Goitrous areas, routine examination of hospital patients, excluding those with thyroid problems (2)	4	—
Goitrous area, autopsy material (6)	23.6	20
Nongoitrous area, survey of adult population (7)	2-3	—
Nongoitrous area, autopsy material (8)	8.2	5.5

CUMULATIVE LIFETIME RISK OF CANCER IN
NODULAR GOITER

The question, "What is the risk that a nodular goiter (even though benign now) will become malignant at some time during the patient's life?" is an important one. This may be approached as follows:

The likelihood that an individual will have a nodular goiter at some time during life may be calculated from the data of Schlesinger *et al.* It is about 10 per cent.

The probability that an individual will develop thyroid cancer at some time during life is easily estimated. About 20 per cent of the population develops cancer. Since thyroid cancer represents 0.5 per cent of all cancer, approximately 0.1 per cent of the population will develop thyroid cancer.

Not all thyroid cancers develop in nodular goiter, so somewhat less than 0.1 per cent of the population will have thyroid cancer arising in nodular goiter.

Since 10 per cent of the population will develop nodular goiter and less than 0.1 per cent, malignant goiter, the cumulative lifetime risk for a randomly selected individual with nodular goiter is less than 1 per cent. Table III summarizes these calculations.

TABLE III
CUMULATIVE LIFETIME RISK OF MALIGNANCY IN NODULAR GOITER

Out of 10,000 people
11 will develop thyroid cancer,
8 in pre-existent goiter.
But,
1,000 will have nodular goiter at some time during life.
Therefore, the Cumulative Lifetime Risk of
Malignancy in Nodular Goiter is 8/1,000

THYROID CANCER AND TOXIC GOITER

Until recently surgery was the only treatment for hyperthyroidism, and even today it is the most com-

monly used form of therapy. The surgical statistics on toxic goiter, therefore, include the great majority of all cases—unlike the situation we have discussed in nontoxic goiter. These statistics make possible an approach to our problem from a different direction.

Figures on the association of thyroid cancer and hyperthyroidism vary considerably. The pooled data from a number of centers in the United States, covering 1,800 cases of thyroid cancer, indicated that almost 10 per cent of thyroid cancer is associated with hyperthyroidism.⁹ However, the prevalence of hyperthyroidism in the United States is not over 0.5 per cent.⁹ Since 10 per cent of thyroid cancer occurs in the 0.5 per cent of the population which is hyperthyroid, thyroid cancer is twenty times as common among hyperthyroid as among euthyroid individuals. Part of this large difference is accounted for by the higher incidence of nodular goiter in the toxic group. About one-third of toxic goiters are nodular. In contrast, only about eight per cent of comparable euthyroid adults have nodular goiter.

Pooled surgical statistics from a number of centers revealed that cancer was found in 0.94 per cent of toxic nodular goiters, and 0.15 per cent of toxic diffuse goiters.⁹ A typical hyperthyroid population of 20,000 would contain 7,200 individuals with nodular goiters and 12,800 with diffuse goiters. Applying the above percentages, we find that such a population would include 87 people with thyroid cancer. Since thyroid cancer is twenty times as common among hyperthyroid as among euthyroid individuals, there would be only four cancers in a comparable group of euthyroid people. Three of these cancers would be found among individuals with nodular goiter. There would be 1,600 such individuals in this hypothetical population. Thus the incidence of malignancy among randomly selected

nontoxic nodular goiters examined at an arbitrarily selected time is indicated to be about 0.2 per cent. This figure is of the same order of magnitude as those derived in the preceding sections. Table IV summarizes the results of these calculations.

TABLE IV
POSSIBLE INCIDENCE OF THYROID CANCER AMONG RANDOMLY
SELECTED INDIVIDUALS. HYPOTHETICAL POPULATION SAMPLES

NODULAR GOITER	DIFFUSE GOITER		TOTAL	
	MALIGNANT	OR NO GOITER	MALIGNANT	MALIGNANCIES
		20,000 Hyperthyroid Patients		
7,200	68	12,800	19	87
		20,000 Euthyroid Adults		
1,600	3	18,400	1	4

SURGICAL STATISTICS ON THYROID CANCER

Our problem may be approached in still another way. Information is available about the number of thyroid cancers biopsied or treated during various time intervals at many medical centers. Table V lists some representative figures. It is obvious that only at a few famous institutions which draw patients from great distances are more than five or six cases of thyroid cancer seen per year.

The annual admission figures for the institutions listed in Table V are of course available. By using the figures in Table II, we can estimate how many patients with nodular goiter must have been admitted to these institutions during the period that a particular number of thyroid cancers were treated. Table VI presents two representative calculations of this sort, one for a goitrous area and one for a nongoitrous area. Again, the incidence of malignancy appears to be well under one per cent.

TABLE V
FREQUENCY OF THYROID CANCER AT SEVERAL INSTITUTIONS.
SURGICAL STATISTICS (5)

INSTITUTION	THYROID CANCERS,	
	PERIOD	AVERAGE PER YEAR
Mayo Clinic	1907-47	26.5
Massachusetts General Hospital	1937-48	9.8
Ochsner Clinic	1942-49	7.3
University of Pennsylvania Hospital	1933-44	5.4
Illinois Research Hospital	1936-48	4.5
University of California Hospital	1935-47	3.8
Michael Reese Hospital	1930-48	2.9
Philadelphia General Hospital	1936-46	2.4
New Haven Hospital	1923-52	2.3
Vanderbilt University Hospital	1925-47	1.0

TABLE VI

INCIDENCE OF MALIGNANCY IN NODULAR GOITER

a. Chicago, Illinois. Pooled data from the Illinois Research and Michael Reese Hospitals.

	PER YEAR
Admissions	23,000
Nodular Goiter (estimated)	4,600
Thyroid Cancer (surgical statistics)	7.4
Per Cent of Nodular Goiter	0.2

b. Philadelphia, Pa. Pooled data from the University of Pennsylvania and Philadelphia General Hospitals.

	PER YEAR
Admissions	35,000
Nodular Goiter (estimated)	1,900
Thyroid Cancer (surgical statistics)	7.8
Per Cent of Nodular Goiter	0.4

RISK OF MALIGNANT GOITER IN MEN VERSUS WOMEN

Nodular goiter is two to three times as common among women as among men.⁸ Thyroid cancer is also two to three times as frequent among women. Therefore, the risk of cancer in randomly selected nodular goiter must be the same for women as for men.

Many surgeons report finding a higher incidence of malignancy in nodular goiter among men than among women.¹⁰ Examination of their statistics reveals the usual sex ratio among the patients with thyroid cancer, but a preponderance of women in the total sample. These statistics indicate, therefore, not that nodular goiter is more dangerous in men, but that more women are operated upon for benign lesions—whether for cosmetic or other reasons.

UNINODULAR VERSUS MULTINODULAR GOITERS

No distinction has been made in this discussion between uninodular and multinodular goiters. Although a number of recent reports have suggested that the incidence of malignancy is higher in uninodular glands, there are not enough statistical data available for analysis with regard to this point. Furthermore, a number of excellent studies have demonstrated that clinical differentiation between uninodular and multinodular glands is subject to very great error.^{11,12} The Mayo Clinic has had more experience with thyroid cancer and nodular goiter than any other institution in this country. At that center the attempt to distinguish uninodular from multinodular glands preoperatively has been abandoned.¹¹

Review of the Grace-New Haven Hospital mate-

rial confirms these reports of large clinical errors in counting thyroid nodules. There is often disagreement among different examiners as to whether a gland is diffusely enlarged, uninodular, or multinodular. And even when all examiners agree that it is uninodular, multiple nodules are often demonstrated in the operative specimen.

These large clinical errors in estimation of nodularity nullify the usefulness of any difference in the incidence of malignancy which might actually exist. However, there is some question as to whether such a difference really does exist. It was reported initially in a series containing many advanced cancers. It is very possible that many of the malignant glands were multinodular to start with, but that nodules were destroyed by carcinoma as it replaced more and more of the thyroid gland, leading to a classification of uninodular at the time of treatment. Such a phenomenon has been reported from our material.⁹ Theoretically it seems unlikely that cancer would develop more frequently in uninodular than in multinodular glands. If one thyroid nodule is a precancerous lesion, it is difficult to see why two nodules should not be two precancerous lesions.

SELECTION IN NONTOXIC NODULAR GOITER

Only a small percentage of nontoxic goiters are operated on. This relatively small group contains almost all of the malignancies. Therefore, the incidence of malignancy among nontoxic nodular goiters coming to surgery is much higher than it is among such goiters as a whole. This has been known for a long time, but appears to have been overlooked by some authors who have written on this subject in recent years. A generation ago, Collier¹³ wrote:

"The ratio of carcinoma to goiters removed varies with the clinic from 1.2 to 4.6 per cent, but this gives an exaggerated idea of the dangers of the adenoma as a precancerous lesion. As Balfour pointed out, patients with cancer of the thyroid eventually seek surgical aid, while the majority of persons with adenomatous goiters are not operated on. The true incidence of carcinoma in adenoma cannot be stated, but it would be very much less than any figures we have at present. The adenoma is a precancerous lesion but the true incidence is so small that it should not be a great cause for anxiety to the person with an adenomatous goiter . . ."

More recently, Crile and Dempsey² have contributed an excellent discussion of this subject. They estimated that at least a tenfold concentration of

cancer had been achieved in the cases in which operation had been performed at the Cleveland Clinic.

Statements by a number of authorities that it is their policy to remove all nontoxic nodular goiters, and by one,¹⁴ that the incidence of malignancy was as high in a series where all nodular goiters were operated upon as in an earlier series when selection was practiced, have led to much confusion. It must be emphasized that even at such institutions, very extensive preoperative selection is taking place. For example, only two thyroidectomies per month in nontoxic nodular goiter were performed at the Illinois Research Hospital during the period 1936-1952.¹⁴ This hospital is located in the major goitrous area of the United States. An average of almost five hundred inpatients per month were admitted during that period. It is quite obvious that the surgical statistics from this institution account for only a small fraction of the nodular goiters admitted.

No definitive studies of the efficiency of preoperative selection in nodular goiter have been reported. Indirect evidence, such as the statistics discussed above, suggests that it is quite high. Crile and Dempsey² present some direct evidence on this point. Additional data are available in a recent report from the Ochsner Clinic.¹⁵ Five hundred and eighty nodular goiters were seen there over a seven year period. Most of the patients were referred, some with the histologic diagnosis of thyroid cancer already established. Excluding these known cancers, there were 252 thyroidectomies. Cancer was found in 43, or 17 per cent of these. For various reasons, thyroidectomy was not performed in 320 patients. None of these are known to have developed evidence of thyroid cancer during a follow-up period of one to seven years. Although this is obviously not an optimal follow-up, this experience does demonstrate that it is possible to select "low-risk" and "high-risk" groups in nodular goiter. (It is of some interest that these results were reported from an institution where thyroidectomy is recommended for all nodular goiter.)

A retrospective study over a much longer follow-up period is now in progress at the Grace-New Haven Community Hospital. The data collected so far parallel the experience at the Cleveland and Ochsner Clinics.

We can, therefore, answer at least tentatively the second question posed at the beginning of this dis-

cussion. Yes, it is possible to differentiate with considerable accuracy between nodular goiters that are benign and those that might be malignant.

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HORMONAL THERAPY IN GYNECOLOGY

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SUMMARY

It should be clear from this presentation that hormones are not miracle substances that will solve all the problems of medical gynecology. Each has specific actions and these should be known before they are administered. Certain gynecologic disturbances may be helped by the use of the right hormone in proper dose but hormones are of little value in many conditions for which they have been employed. Harmful results may follow their improper use. However, if careful thought is given each case and the proper substance employed where indicated the hormones will prove of real value in many gynecologic problems.

Thus, estrogens are of real value in treating the symptoms of the menopause, atrophic vaginitis and

the suppression of lactation and of questionable value in dysfunctional uterine bleeding, amenorrhea, dysmenorrhea, endometriosis and malignant states.

Progesterone may be of value when the corpus luteum of pregnancy is surgically removed and of questionable value in dysfunctional uterine bleeding, amenorrhea, deficient corpus luteum and dysmenorrhea.

The androgens are helpful in treating the menopausal symptoms when estrogens are contraindicated and in the suppression of lactation. Their value is questionable in treating frigidity and malignancy.

Gonadotropins at present have no proved value in gynecologic problems.

Thyroid is of value in treating menstrual abnormalities when associated with deficient function of the thyroid.

Cortisone may be of value in treating certain specific menstrual disturbances due to deficiency of the follicular phase of the menstrual cycle and may also serve as an adjunct in treating advanced malignancy.

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THE use of hormones has frequently become abuse and this applies to gynecology as well as to other branches of medicine. A knowledge of their actions and therapeutic effects as well as their limitations is necessary to use them intelligently.

There are four groups of compounds most frequently used in gynecologic endocrine therapy. Three of these are steroids, namely, estrogens, androgens and progesterone, while the fourth, gonadotropins, are complex protein substances derived from the anterior pituitary or placenta. Within each group there are several substances which vary in their therapeutic actions. Thus there are "natural" estrogens and synthetic estrogens which may also be given in "conjugated" forms. Natural estrogens are relatively ineffective when administered orally whereas the synthetic ones are quite potent. There is usually no indication today for parenteral administration of the estrogens unless a large rapid dose is required or there is a sincere psychological reason for intramuscular injections.

Androgens are much less potent when administered by mouth and thus the injection route may be advisable. Progesterone is also much more potent when given parenterally and, in order to give a therapeutically effective dose by mouth, the amount of material required may be quite expensive.

Gonadotropins, if given at all, are always administered by the injection route.

ESTROGEN THERAPY

1. Menopausal symptoms.

Probably the greatest single use of the estrogens is in the treatment of the menopause. Although estrogens will relieve many of the symptoms of the climacteric, it must be emphasized that there may be a large psychosomatic component associated with the menopause. Frequently attention to this phase of the problem will result in a good therapeutic response without resorting to endocrine therapy. However, if the symptoms are caused by an endocrine imbalance because of removal of the ovarian hormones, the estrogens are very effective in relieving these unpleasant symptoms. They should be given by mouth and started in small doses such as 0.5 mg. daily and increase the dose if necessary. It is advisable to administer estrogens intermittently so there will be no possibility of the development of hyperestrogenism. Thus they may be given for three weeks and omitted for one week.

2. Atrophic vaginitis.

This condition may be helped by the use of vaginal suppositories. One suppository containing 0.3 to 0.5 mg. of estrogen is inserted into the vagina nightly for two weeks and then gradually decreased so only one suppository a week is used.

3. Dysfunctional uterine bleeding.

The estrogens in conjunction with progesterone administered in a cyclic manner may be of value. The explanation for their effectiveness is that the pituitary-ovarian-uterine axis is put at rest and after cessation of the therapy, the patient's own endocrine system will produce the correct balance of hormones and correct the disturbance.

The procedure advised is to give conjugated natural estrone sulfate, 1.25 mg. three times a day beginning on the third day of the menses and continuing through the twentieth day. Progesterone 10 mgs. three times a day is given in addition for the last five days. Bleeding will usually occur four days after cessation of the medication. The course of therapy is repeated for three months and stopped.

If there is severe, acute uterine bleeding, conjugated natural estrone sulfate 20 mgs. may be given intravenously and repeated in 12-24 hours, if necessary. The above cyclic therapy is then instituted.

4. Amenorrhea.

In primary amenorrhea, exogenous estrogen may produce uterine bleeding upon its withdrawal but it does not produce a permanent cure. Secondary amenorrhea may be rectified by the administration of estrogen and progesterone in a cyclic manner.

5. Cessation of lactation.

Estrogens are helpful if given soon after delivery for the prevention of lactation but are much less effective if lactation has already occurred. If given, the dosage should be gradually diminished so as to prevent uterine bleeding by sudden withdrawal.

6. Dysmenorrhea.

If estrogens are given in the first half of the cycle, ovulation will be prevented and there will be no dysmenorrhea unless it is of psychosomatic origin. However, this is only a temporary procedure and should not be employed over a long period. Estrogens are probably of no value in this condition if given at any other time of the cycle.

7. Endometriosis.

Estrogens will prevent ovulation and thus give

relief of pain but the evidence at present indicates that no cure of the endometriosis occurs. Actually there may develop hyperplasia of the endometrium with subsequent abnormal uterine bleeding. Other methods of therapy are much more effective in treating this lesion than endocrine administration.

8. Malignancy.

Estrogens may be of value in recurrent or metastatic lesions of the breast if the patient is at least five years postmenopausal. They are of no practical value in malignancy of the female genital organs.

PROGESTERONE THERAPY

1. Surgical removal of the corpus luteum of pregnancy.

Occasionally an ovarian cyst will be removed during the first trimester of pregnancy and if the cyst is in the ovary containing the corpus luteum of pregnancy, it is wise to give progesterone to replace that produced by the corpus luteum. The dose should be 70-100 mgs. daily until the 12-14 week of gestation.

2. Dysfunctional uterine bleeding.

As previously stated, progesterone used in conjunction with estrogen in a cyclic manner may be of value.

3. Amenorrhea.

It has been considered necessary to have the endometrium "primed" by estrogen before progesterone will produce uterine bleeding. Although this is not always necessary, it is in most cases. Consequently, if uterine bleeding occurs following progesterone administration in an amenorrheic woman, she probably is producing sufficient estrogens and the disturbance probably is one of the luteal phase. This procedure should be considered a diagnostic one and not a form of therapy.

4. Deficient corpus luteum.

Some of the menstrual disturbances, especially polymenorrhea, may be due to a poor functioning corpus luteum or one that degenerates prematurely. In such cases if examination of the endometrium by curettage or endometrial biopsy discloses a poor progesterone effect, the administration of progesterone during the luteal phase may produce a more normal secretory endometrium and thus improve the menstrual disturbance and infertility if it exists.

Although progesterone has been used to benefit dysmenorrhea and premenstrual tension, there is

little evidence from either a theoretical or therapeutic aspect that it has any value.

ANDROGENS

It is a recognized fact that androgens are produced in the human female probably in the adrenal cortex but there is no evidence that any androgen deficiency exists in the female. However, androgens have been used in some gynecologic conditions with varying success.

1. Menopausal symptoms—estrogens contraindicated.

If menopausal symptoms develop following surgery for endometriosis where it is unwise to remove all the endometrial tissue, they are best treated by the androgens for the use of estrogens may produce undesired effects by stimulating the ectopic endometrium.

2. Suppression of lactation.

The androgens are as effective if not more so than the estrogens in this situation. Moreover, there is no danger of uterine bleeding following their withdrawal as there may be when estrogens are used.

As in the case of estrogens, the androgens are more effective in preventing lactation than in suppressing established lactation.

An effective and easy method is to give 20 mgs. of methyl testosterone three times a day beginning during the first twenty-four hours postpartum and continuing for three days.

3. Malignancy.

Recurrent carcinoma of the breast or osseous metastases in the premenopausal patient may be temporarily checked by the administration of androgens. Testosterone propionate should be given in doses of 50-100 mgs. three times a week. This amount of testosterone may produce virilism and one must determine whether or not the improvement following the use of the testosterone is enough to warrant the development of virilism.

4. Frigidity.

A few women who are frigid will be benefited by small doses of androgens such as 20 mgs. of methyl testosterone three times a week. The benefit probably occurs because of engorgement of the clitoris and the improved sense of well being as a result of the anabolic action of the androgens.

GONADOTROPINS

It is very questionable whether or not these sub-

stances at present are of any therapeutic value. Theoretically they should be of value in producing ovulation but experience has proved that with the available preparations it is doubtful that ovulation can be produced by their administration.

One must remember that the gonadotropins in contrast to the steroid hormones are protein substances and thus capable of producing severe allergic reactions.

If they are employed to improve the luteal phase of the menstrual cycle or assist in the treatment of habitual abortion, the dose must not be too large. A dose of 4000 international units of chorionic gonadotropin t.i.w. is sufficient.

The above described hormones are the ones most commonly used in gynecologic disturbances but two other hormones should be mentioned. Thyroid has been used for a long time in menstrual irregularities and infertility with some favorable results. However, unless there is a deficiency in thyroid activity, it is difficult to ascribe any scientific reason for its use. In those cases where improvement is observed and even a correction of infertility has occurred, the explanation is usually a loss of weight and correction of nutrition. If thyroid is used, it should not be given in doses of more than 120-180 mgs. per day unless there is a real deficiency.

The other hormone which has found a place in gynecology is cortisone. Some of the cases of amenorrhea due to defects in the follicular phase have responded to cortisone therapy if given in the manner described by Jones. These cases should be thoroughly investigated before instituting cortisone therapy and the cortisone usually must be used for a long time.

Cortisone has also been of value in the cases of advanced states of malignancy. It is given in doses

of 200 mgs. per day for two weeks. Frequently the patients have an improvement in appetite and general well being and the amount of narcotic necessary to control pain can be reduced. After a rest period of one or two weeks, the course of cortisone may be repeated. We have seen no ill effects from its use if employed in this manner.

The use of hormones in obstetrics, for the most part, has not been discussed in this presentation since gynecology is the subject under consideration. However, many problems of infertility are seen and handled by the gynecologist or general practitioner and it would be advisable to mention one of them, namely, the habitual aborter. Much has been said and written as to the method of treating these patients and many methods of hormonal administration have been formulated. However, the consensus today is that hormonal therapy if of any value should be used in the preconceptional period and not after conception has occurred. A study of the endometrium should be made and if found deficient, 0.1 mg. stilbesterol may be given beginning on the third day of the cycle and continuing through the twentieth day. The course of therapy should be repeated for two to three months and if the endometrium shows improvement, conception should be advised.

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DANGERS OF CORTISONE THERAPY IN PULMONARY LESIONS OF UNCERTAIN ETIOLOGY

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IT is a well known fact that the use of the ACTH and cortisone preparations has its limitations and contraindications. After the enthusiasm of early days, serious question ensued as to the therapeutic value of these drugs and also a great deal of apprehension as to the possible complications "if the contraindications are not carefully evaluated." In many cases the benefit to be gained from therapy had to be weighed against the danger of such complications. One wonders whether there is a clear understanding of what is meant by "careful evaluation" of the contraindications.

In this brief paper we are specifically concerned with only one aspect of this problem, namely, pulmonary tuberculosis, which, as is well known, constitutes one of the major contraindications.

The following two case histories illustrate the difficulties in anticipating complications of cortisone therapy. In both of these cases, we were acutely aware of the potential dangers of this medication but felt relatively safe in administering it to our patients because tuberculosis was absent in the history and could not be definitely demonstrated either radiologically or bacteriologically.

REPORT OF CASES

CASE I

A. H. F., a fifty-four year old white male, decorator, was admitted to the Rocky Hill Hospital on the third of April, 1954 with an eighteen months history of joint and muscle pain involving the knees, hips, neck and elbows. There was also a gradual weight loss of fifty pounds. In February, 1953 the patient was under observation at another hospital and was discharged with the diagnoses of: (1) osteoarthritis of the cervical and lumbar spine; (2) pulmonary tuberculosis, probably inactive, to be confirmed by bacteriological examination; (3) rheumatoid arthritis of the right hand.

Treatment by injections "with a white milky fluid"

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SUMMARY

Two case histories are described which showed development of active tuberculosis during or following cortisone therapy. This brings into focus the general problem of evaluation of the patient prior to administration of ACTH or cortisone. The relative value of different preliminary screening procedures is discussed and the necessity for this routine emphasized.

(the nature of which is not known to us) was given for six weeks by his physician but did not bring any relief. The question of cortisone therapy was brought up at that time but for financial reasons the patient was unable to continue the treatment.

From May until November, 1953 he was treated by a natureopath by spine stretching and "health" tablets without any apparent effect. By this time the patient walked with great difficulty, could not drive his car, and was unable to hold his job.

The past history was noncontributory, except for a non-complicated case of influenza in 1918. The family history was negative for tuberculosis, and as far as the patient remembered he had never been exposed to the disease.

On admission, in addition to the above complaints, there was some shortness of breath on exertion, but no evidence of cardiac failure. Physical examination revealed a chronically ill, white male with pronounced muscular wasting, especially of the extremities. He walked with a wide shuffling gait and any change in position, such as getting up or sitting down, caused considerable pain. The skin was dry and atrophic. There were no palpable lymph nodes. The lungs were clear to percussion and auscultation. The heart was regular. Blood pressure 92/62. No murmurs or rubs were heard on admission. The upper extremities were flexed at the elbows and extension was limited to 130°. There was fusiform swelling of the fingers and a question of clubbing. There was muscular atrophy and muscular weakness and subcutaneous nodules were palpated on the ulnar aspects of both forearms. There was evidence of effusion in both knees. Movements of practically all the joints were painful, especially in the elbows. Neurological examination was negative.

Course in the hospital. The patient was in constant pain, which was somewhat relieved by salicylates. Low-grade fever was constantly present, occasionally reaching 101°. X-rays of the chest showed diffuse areas of honeycombing in both upper lung fields, more noticeable on the right, predominantly in the first, second and third anterior intercostal spaces (Figure 1). These findings were considered as suspicious of active tuberculosis. In retrospect this, however, seemed unlikely because of the lack of change of the lesions over a period of a year (comparison with outside films). Other diagnostic possibilities such as sarcoidosis, lipoid changes (predominance of the lesions in the upper lung fields appeared to be against it), interstitial pulmonary fibrosis, etc., were also considered, as well as pulmonary manifestations of some systemic disease. The x-rays of the skeleton showed moderate degenerative changes in the lumbar and cervical spine.



FIGURE 1, CASE 1

Admission roentgenogram showing bilateral honeycombing in the upper lung fields, before cortisone therapy

Laboratory findings of importance: hemoglobin of 11.4; w.b.c. 9,100 with a normal differential. On repeat examination these were not remarkable. Sedimentation rate varied from 32 to 36 mm. Liver function tests normal except for 3+ to 4+ cephalin flocculation. Extensive blood chemistries were done, all of which were within normal limits.

Lumbar puncture showed no abnormality in dynamics or otherwise. These studies were done because a systemic disease of the spinal cord was suspected originally, since the patient had changes in gait and extreme muscular atrophy. Sternal puncture revealed a normal bone marrow. Urinalysis was normal.

Acid-fast bacilli could not be demonstrated on numerous forty-eight hour concentrated sputa; cultures and guinea pig inoculations were negative. A first strength purified protein derivative was negative on April 26, and a second strength equivocal on May 3; repeated on July 28 and found to be two +.

A liver biopsy (May 7) showed normal liver tissue. A muscle biopsy (May 6) was reported as showing focal chronic inflammation consistent with the diagnosis of rheumatoid arthritis.

Sensitized sheep cell agglutination titer was found to be high (256 units) and antistreptolysin titer was normal. These tests were interpreted as being consistent with rheumatoid arthritis.

While in the hospital the patient developed shortness of breath, a pronounced pericardial friction rub, and also a moderate right pleural effusion with an appreciable increase in size of the cardiac silhouette by x-rays. Fifty cc. of straw colored fluid was removed which was sterile on culture and negative on guinea pig inoculations.

The electrocardiogram showed changes suggestive of myocardial anoxia. After digitalization the heart returned to its original size and the pleural fluid disappeared. Later in his hospital course the patient showed several episodes with similar clinical and x-ray changes.

After evaluation of the clinical picture, x-ray and laboratory findings, a diagnosis of collagen disease was considered. The clinical picture was not typical of any definite one of the collagen diseases, however, but the diagnosis of rheumatoid arthritis, rheumatic fever and scleroderma were considered most seriously.

Because of the severity of the clinical course, and the fact that tuberculosis appeared reasonably well ruled out, the patient on May 14 was started on 60 milligrams of hydrocortone daily. This was decreased to 50 milligrams on June 9, and maintained at this dose for some time. There appeared to be a prompt subjective response to this therapy reported by the patient as a feeling of increased well being, better appetite and considerable relief of pain along with a gradual increase in muscle power.

X-rays of the chest on May 25 showed no change in the previously described appearance. On July 1 the patient developed an acute orchitis which cleared rapidly on penicillin; following that episode, however, there was a gradual recurrence and exacerbation of symptoms, with pain, increasing fatigue, diminished exercise tolerance, despite the fact that hydrocortone therapy was not interrupted. In addition, on July 12 the patient complained of increasing "tightness" around his chest, orthopnea and a productive nocturnal cough. There was again evidence of pleural effusion at the right base. The low-grade temperature persisted all during this time. At this point mercurials were given, resulting in prompt diuresis and some relief of symptoms.

X-ray of the chest on July 12 confirmed the presence of fluid (Figure 2), and showed at this time unfavorable progress of the parenchymal lesions in the upper lung fields bilaterally, particularly on the left side where, in addition to the infiltrative changes, a radiolucent cavity over the third left anterior rib was thought to be visualized; these findings were considered as definitely suggestive of active tuberculosis.

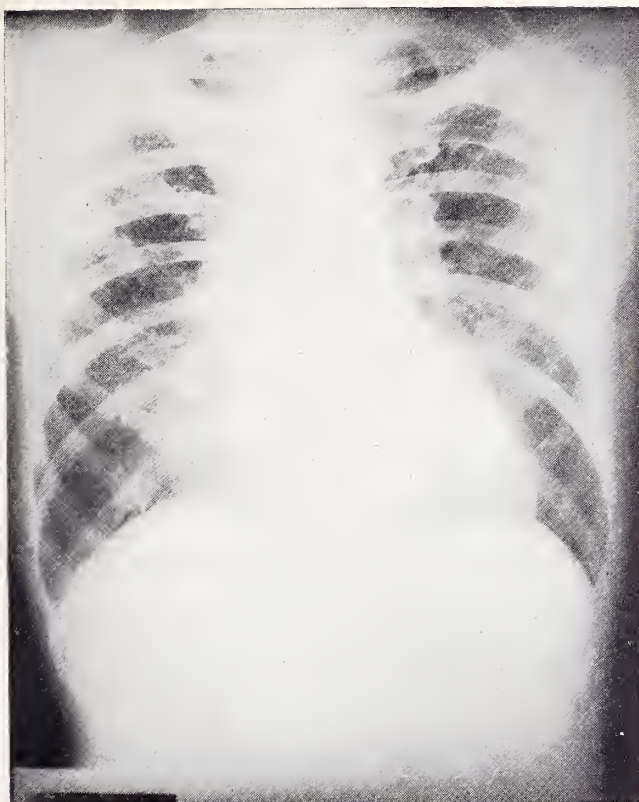


FIGURE 2, CASE 1

Roentgenogram after approximately two months of continuous cortisone therapy, showing an unfavorable progress of parenchymal pathology (positive culture)

Search for acid-fast bacilli was resumed and remained negative on direct smears and gastric washings. Numerous cultures were done. On July 28, purified protein derivative second strength was found to be two +.

A gradual tapering off of cortisone was started. X-rays of the chest of July 22, August 6 and 17 showed no evidence of improvement.

On August 17, a positive culture for acid-fast bacilli (incubated on July 15) was reported.

Following this the patient was started on streptomycin, and on August 23 was transferred from this hospital to a sanatorium where the diagnosis was confirmed; the treatment there consisted of streptomycin, isoniazide and PAS, while cortisone was decreased. He did not do well; at the latest information he is receiving hydrocortone with anti-tuberculous medication.

CASE II

C. G., a fifty-four year old white male, former telegraph operator, had numerous admissions to this hospital since 1949 for a variety of reasons: dental work, domiciliary care, chronic alcoholism, psychoneurosis, vocational retraining, etc. Final diagnoses on all these admissions were those of psychoneurosis and chronic alcoholism.

In December, 1950 a benign rectal polyp was removed. Follow-up studies and history did not suggest any further colon pathology; an x-ray of the chest was negative.

In November, 1953 the patient was readmitted with similar complaints. Physical examination was again negative.

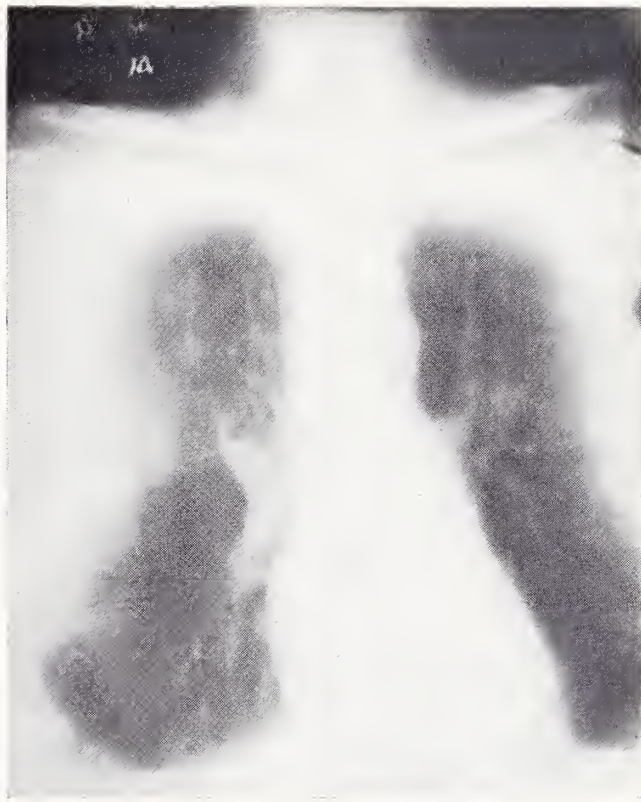


FIGURE 3, CASE 2

Laminagram taken three months prior to cortisone therapy showing a small area of density adjacent to or within the wall of the left upper lobe bronchus

A chest film at this time (Figure 3) revealed a small area of density in the second left anterior intercostal space which had not been present on previous examinations. A tentative diagnosis of early malignancy was considered; exhaustive studies including bronchoscopy, a bronchogram and laminagrams, as well as a complete bacteriological study to rule out tuberculosis were done. All these were negative except for the laminagraphic studies which revealed the area of density to be adjacent to the wall of the left upper lobe bronchus, but there was no evidence of endobronchial disease on bronchoscopy. The investigation for tuberculosis included several forty-eight hour sputa, gastric washings, culture and guinea pig inoculation, which all were negative, the latter as late as February, 1954. The patient was still considered as a malignancy suspect, though monthly follow-up films until March 19 did not show any change in appearance; he was scheduled for three-month follow-up films in the Chest Clinic. His weight at that time was 148 pounds.

Late in March the patient developed a severe hemorrhagic intercostal herpes zoster involving the 8th dorsal root on the right, which was followed by an equally severe post-herpetic neuralgia resistant to all analgesics, high doses of Vitamin B¹², and radiation therapy. Because of severe pain, he was extremely depressed and ate poorly. At no time did he have respiratory symptoms, acute or chronic cough, night sweats or chest pain except in the area involved by the herpes zoster. There was a loss of weight of 14 pounds between March and July 7. This did not appear surprising because of the patient's extreme depression and severe discomfort. On June 23 the dermatological

consultant, who was directing the therapy for his herpes zoster, recommended that the patient be put on 25 milligrams of cortisone t.i.d. No repeat x-ray of the chest was done immediately preceding the administration of cortisone. This therapy was maintained for ten days and resulted in a definite relief of pain.

On July 16, 1954 the patient was discharged from the hospital to the home greatly improved symptomatically. Eight days later, on July 24, he was readmitted to the hospital acutely ill with chills, fever of 101.6, pain in the left chest, productive cough and general malaise. The impression of the admitting physician was that of an acute respiratory episode. On auscultation, rales were heard in the left upper lung field. X-ray examination of the chest (Figure 4) now showed an extensive pneumonic type density over the left upper lung field with at least two large radiolucent cavities, and also an area of density in the right mid lung field. Examination of the sputum by direct smear showed abundant tubercle bacilli, Gaffkey 7. He was transferred to a sanatorium on July 27, 1954, where the diagnosis was confirmed.



FIGURE 4, CASE 2

Roentgenogram taken two weeks after cessation of cortisone (10 days course) showing extensive pathology in the left upper lung with cavitation, and an area of density in the right mid lung field (direct sputum positive, Gaffkey 7.)

COMMENTS

In both cases the patients were followed carefully prior to cortisone therapy in a protected and controlled general hospital environment where the

chances of contact with infectious, open tuberculosis may be considered as minimal.

Both had, from the onset, evidence of pulmonary pathology of uncertain etiology and for this reason were subjected to extensive radiological and bacteriological follow-up studies, all of which were negative. Later on, in both cases active tuberculosis was demonstrated. In retrospect, certain factors in the work-up should have been more carefully considered. In Case 2, the tuberculin test was not done and a repeat chest x-ray immediately preceding cortisone therapy was not taken. In Case 1, because the tuberculin test was not definitely positive, it was thought reasonable to assume that the patient did not have tuberculosis, but that he had pulmonary lesions related to his systemic disease (collagen disease).

The value of a tuberculin test may not be absolute, even in cases where the second strength is negative. There is no doubt a personal factor in the evaluation of the results; a small percentage of cases may show a negative reaction even in the presence of active disease; this may be due to anergy, on the basis of a debilitating disease (which our first patient had). These instances, however, are very rare.

If the procedures described above are routine in any hospital, and even under such "ideal" circumstances are not entirely reliable, what line of conduct then should a general practitioner follow when prescribing this medication in his office? Obviously, such a complete investigation cannot be conducted on every patient on whom ACTH or cortisone therapy is considered.

These drugs at present are prescribed frequently for a variety of conditions in general practice and in numerous specialties (allergy and dermatology, in particular). For practical purposes, routine x-ray of the chest and tuberculin tests may suffice. Tuberculin test is a simple office procedure; x-ray of the chest has become a relatively inexpensive routine procedure available to all.

If the chest x-rays show a lesion of undetermined etiology, a negative tuberculin test would then fortify one in treating that patient with cortisone. In our first case, however, in spite of the equivocal second strength tuberculin test, cortisone was given without protecting the patient with antituberculous drugs. The subsequent development of tuberculosis in that case might have been prevented by such medication, as is suggested in the recent literature dealing with this subject.

PSYCHOSOMATIC APPROACH TO INFECTIONS

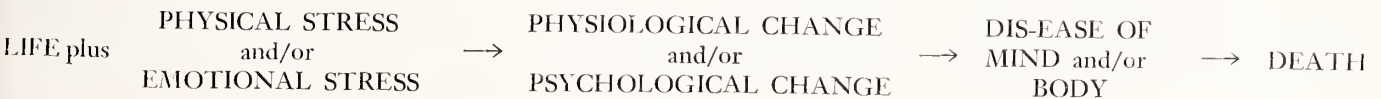
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SUMMARY

The orthodox germ concept of disease has served its purpose. The modern stress concept can more adequately serve to explain the occurrence and recurrence of infections. This article attempts to make this substitution easier by showing that germs only multiply and invade when host resistance has been lowered by environmental stress, both physical and emotional.

THE psychosomatic viewpoint of medicine is based on the assumption that man's mind, body and spirit being unalterably intertwined and interdependent, an injury to one must necessarily cause some change in the other two aspects of his total and three fold nature. This concept has been summarized as follows:



In previous papers chronic disease has been considered in greater detail. This paper is concerned principally with the question: Where does infectious disease fit into the psychosomatic concept? In other words, if chronic diseases are diseases of adaptation to chronic stress of one type or another, where does the acute infectious disease or the chronic infectious disease come into the picture?

THE STRESS CONCEPT

The stress concept is receiving wide acceptance everywhere, not only because of its usefulness but also because it is apparently as near to basic truth as man can put an equation dealing with human behavior, life and death. It stands firmly on evidence gained, not only from laboratory and animal experimental work, but more importantly from the investigative clinics dealing with human beings themselves in many of the great universities and medical schools in this country and abroad. Most of the experimental work being done at the present time centers on the physiological changes induced in the human being who is placed under emotional stress by the investigator. The stress is

achieved by applying the examiner's knowledge of his subject's past experience in such a way as to induce a bad emotional state by the discussion of subject matter which either frightens or angers the person. These studies have shown not only instantaneous gross changes of physiological function but all sorts of detailed changes which require study by chemical methods of precision and analysis. Hence, it seems that all evidence, as it pours in, is supporting the hypothesis that whereas physical stress may well cause a physiological disturbance, an emotional stress may be equally potent in causing such a change. Furthermore, throughout the past thirty years, in our endless search for the factors responsible for physiological changes manifested by symptoms of one sort or another, we have been totally unable in many instances to find adequate physical factors (such as poisons or germs) to account for the changes observed. This has been notably true in the field of chronic disease which is under such close scrutiny at the present time.

If we now return to the equation written above and rewrite it in shorter form we have:

$$\text{STRESS} \rightarrow \text{PHYSIOLOGICAL or CELLULAR CHANGE} \rightarrow \text{DIS-EASE}$$

It must be remembered, however, that this does not mean that all stress leads to change or disease. The body and mind have a most marvellous power of adapting to stresses of all kinds. However, when this adaptability is exhausted or when no other adaptation seems possible (whether consciously or unconsciously) then changes take place as formulated by this equation.

Now if we substitute for "physiological or cellular change" the words "cellular resistance" we can see that it is at this point that a bacteria, a virus or other pathogenic organism enters the picture. In other words, when stress has altered cellular resistance sufficiently, the specific agent (germ) gains a foothold in the living cell or host.

GERM THEORY OF DISEASE

The proponents of the germ theory of disease, which has dominated the scene for the past seventy-five years, have made enormous contributions to the advance of medical science through the discovery and identification of the various bacteria

and viruses and by the subsequent development of immunological procedures to help combat them. This work has culminated in the so-called "miracle drugs" of the present day, namely the antibiotics, such as aureomycin, streptomycin, etc., which have specific bacteriocidal properties.

On the other hand, the students of the psychosomatic concept of disease are coming to realize that the germ theory of disease is inadequate. Germs are normal inhabitants of every external surface of the body and most of the lining mucous membrane surfaces of the body. These bacteria and viruses are kept in check by the natural homeostatic forces of resistance of the body. What are the factors which change this resistance? Attempts at explaining the factors of resistance have been largely physiological and immunological in nature but attempts at going back of the physiological and immunological changes have not been made because no concept was available. We may now write the hypothesis that stress causes physiological change as:

STRESS \rightarrow LOWERED CELLULAR RESISTANCE

and we see that:

LOWERED CELLULAR RESISTANCE plus A VIRUS \rightarrow INFECTIOUS DISEASE

STRESS THEORY OF DISEASE

We can now see that the stress factors are what determine cellular or body resistance. The author is not attempting to analyze the biochemical or physiological changes in the cell. He is merely pointing out that the countless environmental factors which lead to physical and emotional stress may all play a part in changing cellular resistance. The pathogenic organism may be very virulent, it undoubtedly sets the pattern of the type of disease process which it alone can evoke, but only on fertile ground—only when, as, and if, body resistance is such as to permit a beach head. It may seem more logical and helpful for us then to abandon the concept that germs cause disease and to consider that when an individual is subjected to physical or emotional stress sufficient to upset the body's homeostasis and integrity, or its adaptation to the total environment, the virus or bacteria begins to invade, and invasion by the virus or bacteria means infection. Hence we may write the equation:

STRESS plus INFECTIOUS ORGANISM \rightarrow INFECTIOUS DISEASE

CONCLUSIONS

As long as man clings to the concept of germs as the single cause of infectious disease he will have fear of his invisible assailants, as seen in the public terror of poliomyelitis. The physician should continue to use bacteriocidal agents, supportive physical means and preventive immunological methods to combat infections, but he should also consider that the understanding, modification or elimination of the physical and/or emotional stresses besetting the infected human being may be equally important not only in helping the patient recover from his disease but in preventing its recurrence. Total therapy is not only the best therapy but it is the best preventive medicine.

Furthermore, if studies along this line are undertaken by the physician, he will find that even with infectious disease the human being is making the best adaptation he can to his total environment, that good usually can be gained and often is being

obtained by temporarily succumbing emotionally to a particular infection. If we fear disease, it adds to our burden of stresses which in itself may lead

to more disease. This is a vicious cycle which should yield to the impact of a better understanding of all of the forces concerned in disease.

CONVULSIONS DUE TO N-ALLYLNOMORPHINE

A Case Report

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N-ALLYLNORMORPHINE hydrochloride (Nalline, Merck) is a derivative of morphine described as a specific antidote to the respiratory depression caused by morphine, meperidine and methadone. Experimentally it restores toward normal the central vasomotor centers, central nervous system, and electroencephalogram depressed by morphine poisoning. It is reported to be ineffective against respiratory depression caused by barbiturates or gaseous anesthetics.

Unlike the analeptics, coramine, metrazol and picrotoxin, it does not stimulate the central nervous system. No instances of convulsions caused by N-Allylnormorphine have been reported to date.

CASE REPORT

About 5 P. M. the day of admission the patient swallowed twenty tablets of morphine sulphate (300 mgm.) and twelve capsules of pentobarbital (1.2 Gm.). She was seen by her physician at 6:10 P. M. who gave her 250 mgm. of coramine intramuscularly. She was admitted to the hospital immediately.

In the Emergency Room she was comatose, cyanotic, flaccid and did not respond to any stimulus. Her respiratory excursions were very deep; the rate was two or three per minute. The pulse rate was 88 per minute. The blood pressure was 80 mm. Hg. systolic and 50 mm. Hg. diastolic. Her pin-point pupils were indicative of morphine poisoning. Endotracheal intubation (Portex #8) elicited no response. Oxygen (7 liters per minute) caused the cyanosis

of her nail beds and face to disappear. Inspiratory positive pressure with oxygen through the endotracheal tube was applied at a rate of 20 per minute. Within five minutes she sat up, removed the tube, and told us that she had attempted suicide with morphine. This sudden improvement may have been due to increase in respiratory minute volume and subsequent loss of CO₂ which may have been present at a tension high enough to be narcotizing. With this definite history of morphine ingestion, it was thought that her improvement might be temporary. N-Allylnormorphine 5.0 mg. was given intravenously with the hope of avoiding recurrence of respiratory depression. Immediately the patient breathed deeply at a rate of approximately 60 per minute. In less than a minute she convulsed. The convulsions were clonic, lasted three minutes, and simulated those caused by strychnine. The administration of oxygen was necessary. While convulsing her pupils became widely dilated and her eyeballs were in wandering motion. For the next eight hours her coma was apparently deeper than it had been before the N-Allylnormorphine was given; it was possible, however, to arouse her with spoken commands. Sixteen hours after ingesting the morphine she recovered sufficiently to go to the ward. In two weeks she returned to her household tasks without evidence of central nervous system injury.

COMMENTS

A report of attempted suicide by means of ingestion of a combination of morphine and pentobarbital has been presented. A totally unexpected response to the administration of N-Allylnormorphine was observed. This information is offered as a warning that N-Allylnormorphine may act as a convulsant and depressant even after administration of morphine for which it is considered ordinarily a satisfactory antidote.

RETROPERITONEAL MYOSARCOMA

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RETROPERITONEAL myosarcomas are very rare. Although myosarcomas may occur in the forms of embryomas or teratomas in children, it is most unusual to find one attached, retroperitoneally, in the neck of the bladder. There have been various reports by the genitourinary surgeons that rhabdomyosarcoma does occur in the neck of the bladder but very few cases have been reported. The Children's Hospital (Boston) group¹ considered this an "unattached retroperitoneal embryoma." The adjective "unattached" is meant to indicate that it is not connected with the kidney. Gross² reported on only 11 patients with retroperitoneal cysts or teratomas in the Children's Hospital. They believe that all these tumors arise from the remnants of the primitive pronephros or mesonephros and hence may be found on either side of the vertebral column from the fourth cervical segment down as far as the internal genitalia. Hansmann and Budd³ first drew considerable attention in 1932 with an excellent description of massive unattached retroperitoneal tumors and they concluded that the tumors arise from remnants of the urogenital apparatus as being the most logical explanation of their histogenesis. Arnheim⁴ has reported on 39 patients and Palumbo⁵ and his associates reported on 58 cases which they had collected from the literature up to the time of publication in 1949. In only one case reported by Palumbo was there a myosarcoma and this was in an adult. Pack *et al.*⁶ reported a very extensive collection but did not mention any tumors attached to the bladder. They mentioned one specific case in the pelvis which was attached to other organs and required wide excision. They called this an "embryonal rhabdomyosarcoma." Their prognosis on these tumors was very bad.

According to the classification of Willis,⁷ embryomas and mixed tumors are differentiated on the grounds that they represent tumors of tissues indigenous to an organ or region. Teratomas are characterized as being a true tumor or neoplasm composed of multiple tissues of kinds foreign to the part in which they arise. The case presented certainly does not fulfill the requirements for a teratoma and its true classification is difficult to ascer-

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SUMMARY

An unusual tumor in childhood is presented.

It was resected only by transecting the neck of the bladder.

Cysto-urethral anatomy was restored by the use of a Foley catheter and traction.

tain. It is presented because of its rarity and because of the technique used in order to completely resect the mass.

CASE R. F.

This 15 month old child was seen at the Mt. Sinai Hospital on July 28, 1954 because of a distended abdomen and a mass in the lower portion of the abdomen. Except for some nausea and vomiting during the first few months of life, the child had progressed well. A few weeks prior to admission the parents noted a very large abdomen and called the doctor. He felt a mass and sent the child into the hospital.

The physical examination revealed a well developed, well nourished, 15 month old boy whose general condition was good. He weighed 26 lbs., 2½ ounces. Heart and lungs were negative. The abdomen was greatly distended and the child cried constantly when the abdomen was palpated. A large mass was made out in the lower abdomen. On rectal examination there appeared to be a large mass anterior to the rectum.

While in the hospital it was noted that the child did not eat well though he did drink milk and fluids. X-ray studies were made and an I.V.P. showed the ureters to be displaced laterally and dilated. The GI. series and barium enema both showed a large mass in the pelvis with displacement of the small intestines upward while the rectum seemed to be encroached upon anteriorly. A cystogram was accomplished and this showed the bladder to be pushed up forward, practically out of the pelvis. No definite change in the rectal or bladder walls was noted. Stools were small and of ribbon consistency. A diagnosis of retroperitoneal tumor was made and the child was prepared for operation.

Exploration was immediately carried out and a large well encapsulated tumor mass was felt occupying most of the pelvis. The bladder appeared to be completely elevated, almost entirely out of the pelvis. The ureters were dilated and were easily identified. They appeared to be entering the bladder at about a suprapubic level. The mass was freed from all its attachments except for a small portion underneath the

pubic bone. Here it was attached to the distended, stretched out neck of the urinary bladder. In order to completely remove the mass it was decided to transect the neck of the bladder. When this was accomplished the mass was lifted out of the wound and remained attached to the wall of the bladder. With the small opening in the bladder, the ureteral openings were identified. It was noted that they were above the point of attachment of the tumor mass. The lower neck of the bladder with the mass was resected. A Foley catheter was then placed through the penis and into the opening at the neck of the bladder so that with traction on the Foley catheter, the bladder could be held down into its proper position. No sutures were placed to hold this there. A suprapubic cystotomy was also carried out. The patient withstood the operative procedure very well.

The convalescence was a little stormy as anticipated. No urine was secreted for 14 hours. After this there was a bloody urine for about 6 hours. Following this the urine became clear and drained through the suprapubic tube. Daily irrigations were performed between both tubes. On August 2 the suprapubic tube was clamped one hour off and one hour on and on August 3 it was removed.

The pathological specimens were referred to various pathologists and many different opinions were expressed. The majority opinion was that this was a myosarcoma, some claiming it was of the smooth muscle variety and others, of the striated muscle variety. A specimen was sent to Dr. Farber at the Children's Hospital in Boston and he reported this as a possible neurofibrosarcoma. Although most authorities felt that x-ray therapy would be of no avail, there could be no harm in giving some. On August 6 x-ray therapy was started and after the child had received about 1,000r this therapy was discontinued because of the systemic symptoms. The patient's blood count had dropped considerably and he appeared to be in very poor condition. His weight was now 22 lbs. There was a considerable amount of diarrhea, as well as nausea and vomiting during the therapy. On August 11 the patient began to void spontaneously around the Foley catheter and after a cystogram was taken, showing a small but normal bladder, the catheter was removed. He began to eat better and put on weight. The only positive finding at this time was continued pus in the urine. He was treated with some of the antibiotics but continued to show pus cells and *B. coli* in the urine. An I.V.P. on August 24, showed some blunting of the kidney calyces. Despite this the child was sent home on August 26.

He returned to the hospital on September 26, 1954 for a further genitourinary work-up. The I.V.P. showed a small bladder with some degree of hydronephrosis and hydroureter. The ureterovesical junction appeared to have a stricture but was dilated by the urologist (Dr. Benjamin Salvin). Following this the child was sent home again and repeated weekly urinary studies revealed a definite decrease in the amount of pus cells so that on the last examination, in November of 1954, he had only a few pus cells in the urine. His general condition was good. He was putting on weight, was eating well and now weighed 27 lbs.

In December of 1954 examination revealed recurrence in pelvic floor. He was sent to the Children's Hospital in Boston where he died on March 11, 1955.

These tumors are predominantly lesions of young individuals. They may be detected within the first few months of life. Slightly more than half of them appear within the first year. About two-thirds have appeared in the first two years and the remaining are scattered through childhood. Females are somewhat more affected than males. The presenting complaint is a rather silent and progressive swelling in the abdomen. The masses are rather firm with fairly well defined borders and it is only after they have attained a large size that they are easily palpable. There is usually distention of the abdomen with dilated veins over the abdominal wall. X-ray examination shows a shadow generally in one side of the abdomen.

The prognosis as a whole is hopeless. A rare embryoma case has survived but there are no reports in the literature at present of a myosarcoma that has survived any long period of time. As a rule these tumors recur locally in four months and the average life expectancy is usually not more than 14 months.

This case has been most interesting and unusual and it is very difficult to ascertain in what etiological classification this tumor falls. Most of the pathologists who examined the tumor felt that it was a myosarcoma, pure and simple, but they could not be certain as to whether this was a leiomyosarcoma or a rhabdomyosarcoma. One authority felt that this was a neurofibrosarcoma. Because of the uncertainty of the diagnosis it has been classified as an unattached retroperitoneal embryoma. Not only is this case unusual in its pathological findings, but it was most unusual in its position and in the manner in which it was completely enucleated.

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THE VALUE OF FEDERAL-STATE COOPERATION TO CONNECTICUT

A. L. CHAPMAN, M.D., *New York City*

THE entrance of the Federal Government into the field of public health was not accidental. It came about way back in 1798 when the Congress of the United States passed a law establishing the Marine Hospital Service for the relief of sick and disabled seamen.

Congress passed this law for several reasons. The first of these reasons was the constant fear that merchant seamen arriving from foreign ports would bring diseases such as cholera, smallpox, and plague into the country. The second reason was that the financial burden of the care of sick merchant seamen fell primarily on a few coastal States. This burden was more equally distributed when the care of merchant seamen was made a federal responsibility.

Today the Federal Government through the Public Health Service still provides protection against diseases from abroad, it still provides medical care for merchant seamen and other similar federal beneficiaries but, in addition, it has assumed several other equally important responsibilities. It has taken steps to prevent the spread of infectious diseases from State to State and it has recognized the fact that the best way of minimizing the danger from the inter-State spread of disease is to help the States to eliminate diseases locally, at their points of origin. Finally, the Federal Government has undertaken to support the States in their efforts to improve the health of all of the people. People are a nation's greatest resource and healthy people are a much more valuable resource than unhealthy people. The Public Health Service tries to discharge its many responsibilities in a logical and orderly fashion.

RESEARCH

Since diseases cannot be prevented or cured until their cause and their means of transmission are known, the Service engages in research and allots research grants to individuals and to institutions. The total dollar value of research grants to Connecticut during the past three years was \$1,526,332. In return for these grants, research workers in Connecticut have made excellent contributions to

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SUMMARY

Attention is called to the historical development of the part played by the Federal Government through the U. S. Public Health Service in providing protection against diseases from abroad, in providing medical care for merchant seaman, and in recent years in supporting the States in their efforts to improve the health of all the people.

The various means used in carrying out the last function are outlined: namely, research, dissemination of health information, collection and use of vital statistics, development of pilot studies, training of various kinds of technicians and of professional public workers including nurses, providing consultation services to State and local health departments, loaning of personnel to these same health departments, and allotting grants-in-aid to the States. The author points out the various ways in which the Federal Government has improved the lot of the public health nurses in Connecticut and appeals for teamwork in an effort to improve the health of the people.

national disease prevention and control efforts. Today the attention of many research workers is focused on the chronic noninfectious diseases, seeking their cause, tracking down their ancestry, developing better methods of combating their destructive effects.

The discovery of cortisone; the development of better methods of treating epilepsy; dramatically new and more effective types of cardiac surgery; isoniazid and other drugs for tuberculosis: scientific morsels such as these have merely whetted the appetites of research workers who now are hot on the trail of arteriosclerosis, cancer, hypertension, and diabetes. The day will come, hopefully in the not too distant future, when blood tests will be available for cancer, arteriosclerosis, and many diseases of

metabolic origin. When tests such as these are perfected and are put to use finding cases of chronic disease routinely and early, we will have to pay tribute to research workers whose untiring inquisitiveness will be responsible for them.

HEALTH INFORMATION AND VITAL STATISTICS

To unearth new scientific facts and allow them to remain unused on laboratory shelves or to gather dust in libraries is unjustifiable. So the Public Health Service constantly seeks means of disseminating scientific information and new medical facts to physicians and laymen. Vital statistics are collected relating to deaths and illnesses, to marriages and births, so that those who chart the public health course of the States may have useful landmarks to guide them.

Vital statistics always have been the stepchild of public health. Their collection, tabulation, and analysis is not a particularly glamorous or exciting occupation. Yet, when time and money is wasted in the conduct of public health programs, an investigation usually brings out the fact that the program has been devised and administered without guidance from vital statistics. Conversely, most productive public health programs are built on a bed rock of good statistics. Many thousands of dollars can be wasted if we fail to attune our control programs to diseases and conditions which currently cause the greatest amount of morbidity and the greatest number of deaths. That is why public health programs currently are changing their direction and are being related more closely to the control of the cardiovascular diseases, cancers, and accidents.

PILOT STUDIES

One of the necessary steps that have to be taken in translating research findings into preventive programs with a mass application potential is the development of "pilot studies." The Public Health Service constantly works with State and local health departments to help in the development of pilot studies in which research findings may be tried out on a limited basis before their use on a large scale is attempted. In this way the wheat can be separated from the chaff in a local program before a method of operation is recommended for a wider trial or for nationwide application.

Through pilot studies the efficacy of chest x-rays for the early detection of heart diseases as well as tuberculosis is being evaluated; educational techniques for patients with diabetes have been devel-

oped; cancer detection methods have been refined; and home accident prevention programs have been made more effective and more practical. The pilot study exemplifies the principle applied by industry when newly developed goods are tested in the crucible of actual use under controlled conditions before they are offered for sale to the public. Industry cannot afford to market untried and unproven articles of merchandise. Nor can public health administrators afford to sponsor new public health programs until they have been thoroughly evaluated in well controlled pilot studies.

TRAINING

The Public Health Service has helped the States materially to meet their training responsibilities. In many areas of professional competency only a few technicians in each State need training at any given time. It often would be uneconomical for a State to attempt to meet its intermittent needs for training by conducting training courses for only a few students. On a nationwide basis, however, such training often can be provided more economically.

The Communicable Disease Center in Atlanta, for example, has been active in providing training courses for a wide variety of professional public workers. In the east, training centers have been established in Amherst, Massachusetts and Yonkers and Schenectady, New York. Laboratory technicians in many States have been trained to do prothrombin determinations, in making and evaluating smears for parasitic diseases, and in doing blood sugar determinations. Recently chronic disease refresher courses have been held for nurses in heart disease and in chronic disease control. Courses related to diabetes control are being offered at the City Hospital in Boston. Many other examples of similar training opportunities offered to State and local public health workers, including nurses, could be cited.

CONSULTATION

In a similar way the Public Health Service has been able to provide technical consultation services to State and local health departments upon the request of the States. These usually are services which are not repetitive. They commonly involve situations that crop up from time to time. It would be uneconomical for most State Health Departments to maintain a staff of specialists trained in every phase of public health. Therefore, when an unusual consultative need arises, State health officers have

learned to request the services of a wide variety of consultants through Public Health Service regional offices. These services may be provided by the staffs of the regional offices themselves, from the staffs of pilot studies situated within the States, by consultants from the central divisions of the Service or from the National Institutes of Health.

One of the more routine types of consultant services provided by Regional office consultants consists of bringing information to the States concerning public health programs that are being conducted in other States. All of us tend to borrow successful methods of operation from fellow workers. In a sense, regional office consultants "quick freeze" experiences gained in one State and "thaw them out" for the benefit of public health workers in other States. By making its consultation services available to State health agencies, the Public Health Service actually becomes a member of the State health agency team. It supplements and back stops State health agency programs.

LOAN OF PERSONNEL

The loan of personnel by the Public Health Service to State, and through State to local health departments, serves many purposes. A State health department may wish to send an important staff member away for a year of postgraduate training. In this case the temporary loan of a Public Health Service officer often fills the gap on the staff very nicely. Or a State Health Officer may wish to inaugurate a new type of public health program right away. He may be unable to mobilize his recruitment and training machinery overnight. In such a case the loan of an officer often helps him out of his dilemma. In turn the Public Health Service benefits from such an arrangement for it is through State and local assignments that younger Public Health Service officers get practical experience in public health administration. Without this they tend to be too theoretical in their approach to practical public health field problems.

There is no better way of blending the interests of State and national health programs than by the loan of Public Health Service personnel to States for limited periods of time. The high degree of specialization that has developed in public health programs during the past twenty years has made it essential to develop a fluidity in the assignment of public health personnel for their own development and growth.

GRANTS-IN-AID

Finally the Federal Government long ago realized that diseases do not recognize State lines. Hence they must be eradicated at their source. To help the States to do this job, the Federal Government began the practise of allotting grant-in-aid funds to States so that they could build stronger defenses against disease.

There are two facts which have an important bearing on the grant-in-aid mechanism. One is that unhealthy people make poor producers. Poor producers in one State affect the health and welfare of people throughout the United States because they are unable to carry their fair share of the tax burden and cannot produce their share of the nation's goods and services. Without the purchasing power of the people in the poorer States, the income of manufacturers in the richer States would be sadly depleted and their employees would suffer.

The other fact is that some States are far better equipped financially to meet their public health problems than are other States. The ability of rich States to discharge their responsibilities better is not necessarily a sign of their superior industry or intellect. Quite often it is the product of their benevolent environment in the form of natural resources, good harbors, abundant water power, or ample water and a rich soil.

It is not unusual for richer States to resent the contribution they make to the solution of the health problems of poorer States. This attitude is understandable. However, the richer States in lending a financial hand to poorer States are actually making an investment in their own survival. If the time ever comes when six per cent of the world's population (that's us) has its back to the wall, the level of health of all of our citizens may spell the difference between survival and destruction. Connecticut has benefitted materially, along with all the other States, from the grant-in-aid programs.

Venereal disease activities never really got underway in the United States until the first venereal disease grant-in-aid funds were made available in 1938. Since then these diseases have been brought down to a level once believed to be unattainable. Their substantial eradication is not beyond hopeful accomplishment.

Tuberculosis control activities were greatly stimulated by the grant-in-aid program which began in

1944. You all are aware of the consistent decline in mortality from tuberculosis which promises the eradication of this disease as a national health menace within the next decade or two. It soon should be relegated to the museum maintained for lost and rare diseases, there to keep company with diphtheria, typhoid fever, cholera, smallpox, and plague.

Deaths from the infectious diseases of childhood and maternal deaths declined rapidly coincidentally with the development of grant-in-aid programs in this area of public health. Connecticut, by the way, should be proud of the record it has established in consistently having one of the very lowest infant mortality rates in the nation.

At the other end of the age spectrum life expectancy has shot up from 49 years in 1900 to its present all time high level of 68 years, in Connecticut as well as throughout the nation.

Grants-in-aid alone cannot be credited with these health miracles, but they helped considerably. They stimulated the development of new control programs. They brought about a concentration of funds and personnel on one major public health program after another. And they helped persuade State and local appropriating bodies (through the matching mechanism) to invest more funds in programs designed to protect and improve the health of the people.

It is a peculiar thing about grants-in-aid that once they have accomplished their purpose by stimulating the development of a new program, the program seems to develop from that point on through greater and greater State and local and less and less federal participation. After all, that is the way it should be. In other words the grants-in-aid help the States to help themselves, to do the job that has to be done, quicker and better.

Now that past successes have brought many of the infectious diseases under control, the character of grants-in-aid is changing in response to a change in the character of our major public health problems. The more recent grants-in-aid have been for mental health programs, for heart disease control programs, for cancer control programs, and for hospital and health center construction.

The grants-in-aid for hospital construction under the terms of the Hill-Burton bill now has been extended to 1960. These grants have helped Connecticut to build new hospitals, health centers, and other

facilities associated with them. Since 1948 funds in the amount of \$4,645,000 have been allotted to Connecticut for this purpose alone. Twenty projects have been completed, including new hospitals, additions to existing hospitals, public health centers, nursing homes, and training facilities. Four more projects are under way which will add 344 new hospital beds to the 638 beds already added to various Connecticut hospitals.

The recent Congress extended the Hill-Burton bill to include the construction of rehabilitation centers, diagnostic centers, nursing homes, and chronic disease facilities. The stimulus of these funds, once their effect is felt within the States, should greatly improve the number and the type of facilities available for the early diagnosis of patients suffering from latent chronic diseases and for the rehabilitation of those persons whose diseases have resulted in extensive disability.

PUBLIC HEALTH NURSING

Since the shift of emphasis in public health from the control of the infectious diseases to the control of the chronic diseases will be reflected in a change of emphasis in nursing services, perhaps this is a good place to discuss ways in which the activity of the Federal Government has bettered the lot of public health nurses in Connecticut. The stimulation of public health programs by grants-in-aid definitely resulted in a great upsurge in the number of public health nurses employed by State and local health departments. Increased activity in venereal disease control and tuberculosis, in school health, and maternal and child health, and more recently in heart disease, cancer, and mental health programs, have dramatically increased not only the total number of public health nurses employed but also their stature.

Public health nurses always have been the foot soldiers in our public health army. Without them no battle could be won, no victory could ever be consolidated. They are the ones who come to grips with the enemy. Among their ranks have been the greatest number of unsung and too often unhonored public health heroes, or should I say heroines. But at long last increased training opportunities are being offered to many public health nurses, and clinical nurses as well, because of the broadening of public health horizons and the increased degree of specialization within the nursing profession.

The stimulation of Hill-Burton grant-in-aid funds

has resulted in the construction of so many new hospitals a concerted effort now is under way to recruit additional nurses that will be needed to staff them. Never before have nurses of all kinds been in such demand. This should not be too unpleasant, for nurses (usually) are women and, I have been given to understand, women do like to be popular.

During World War II the nurse cadet program resulted in the recruitment and training of many thousands of nurses who now are staffing hospitals and performing public health duties in every State of the Union. Not only did the nurse cadet program improve the lot of nurses and help fill an urgent need for their services, it also resulted in the honoring of a nursing leader by appointment to a grade equivalent to General.

The increasing emphasis that law makers are placing on the development of improved health facilities in the States and communities suggests that never before in history has the nursing profession been faced with so great a challenge nor has it ever been presented with so many opportunities for increasingly important public service. Nurses will be faced with the necessity of learning new skills, undertaking new types of programs, and remaining undaunted by the impact of many new ideas. There will be more demands for home nursing services as home care programs are developed to meet the high cost of hospitalization. The need for refresher courses will be increased as nurses are asked to become familiar with the idiosyncrasies of patients with heart disease, cancer, and mental illness.

The nurse, in the future, will find increasing emphasis placed on teamwork. She will have to pass the ball to social workers, nutritionists, health educators, and a variety of other newer members of the total health team in the community. In learning to do this she will grow professionally, and will be better able to serve and help her patients. I think we can safely say that nurses in Connecticut have been benefited by the cooperation of the Federal Government with the State of Connecticut.

In looking ahead, if one could disregard the ever present threat of war and think only in terms of health and disease, optimism would be in order. Keys have been found which have unlocked most of the mysteries of the acute infectious diseases. Keys are being forged that promise to lay bare the secrets of the virus diseases so that vaccines may be made available which will give lifetime immunity to such ever

threatening epidemic diseases as poliomyelitis and infectious hepatitis.

We still do not know the fundamental causes of cancer, or arteriosclerosis, or hypertension, or diabetes, or many types of accidents, but enough is known to better the lot of persons who have these diseases or who have been disabled by accidents. If found early enough, many of these diseases can be stabilized, a few can be cured. Research workers in increasing numbers are probing for the cues that will lead us to a solution of these age old disease problems. One by one these cues will be found, in fact are being found. Since we all must die of something or other, sooner or later, the point at which we should become discouraged is more of a philosophical than a medical question. Shall we finally succeed in prolonging our life span to an even hundred years and then proceed to blow each other, and the world we were born into, to Kingdom Come?

Be that as it may, and to get back to the subject and conclude it, for the first time in history scientists have given us extremely potent weapons with which to combat disease. We have learned a lot about using these weapons. However, there still are many people who now are incapacitated who could be made whole again; there still are many people suffering from serious chronic illnesses who do not know that they are sick; there still are many people who die prematurely each year because of failure to apply the facts now in our possession. These are our greatest challenges.

Research workers are doing their job better than we are. They are turning out new discoveries which can revolutionize our battle against disease if and when they are put fully to use. Can we meet these challenges successfully? Can we place the welfare of others above our own welfare at all times and under all circumstances? Can we apportion less of our local, State, and national income for nonessentials and more to preserve our health? Can we adjust to changing times without losing our perspective? Can we avoid partisanship and bias during the evolutionary period ahead of us?

Can we, in short, work together more closely as a team dedicated to only one purpose, the improvement of the health of the people, so that the wonderful discoveries of modern science can better benefit the ill, rehabilitate the disabled and preserve the health of those of us who, for the moment, seem to be well?

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EDITORIALS

Hospital Administration

Announcement of a \$750,000 gift to Cornell University from the Alfred P. Sloan Foundation for establishment of the Sloan Institute of Hospital Administration is welcome news. As the specialty of hospital administration has developed in recent years some thirteen schools have been established in Universities from Yale in Connecticut to U. C. in California. Most are two year postgraduate programs with one year of didactic teaching and one of residency; about half are in schools of Public Health and half in schools of business. Cornell, well known in both fields, will locate the Sloan Institute at Ithaca (site of its school of hotel management) under the dean of its Graduate School of Business and Public Administration. The proposed program appears unique in two aspects: two years rather than one will be spent "on campus" prior to the residency and, of at least equal importance, substantial funds are set aside for research.

As the progress of medicine brings us into ever more intimate contact with the hospitals where we serve, the selection and training of hospital administrators must concern us more and more. The addition of a fourteenth school in this specialty, together with its program of research is a real advance. The presence of Raymond P. Sloan, president of The Modern Hospital Publishing Company and a recognized authority, as head of the school's advisory panel will insure that its horizons encompass all of the broad field of hospital administration.

It is to be hoped that in our zeal for providing

the best possible in training for the administrator we will make the field even more attractive to the physician interested in administrative medicine. He fills a need perhaps more specialized than that filled by the lay administrator, but none the less great.

The Abuse of Estrogens

Elsewhere in this issue a prominent gynecologist in New York City outlines the proper uses of the various hormones in gynecology. He makes certain pertinent statements which will bear repeating for emphasis. One of these, "hormones are of little value in many conditions for which they have been employed," points to the promiscuous use of estrogens in women over forty who complain of various nervous symptoms and by suggestion (see any of the current popular magazines) are convinced they are suffering from the "change of life." Many of these women have eight to ten years of menstrual life ahead and to start prescribing hormones for them in this premenopausal decade serves only to produce menorrhagia and polymenorrhea severe enough to require hospitalization and a diagnostic and therapeutic curettage.

There is no argument where the patient has passed the menopause and requires intermittent estrogen therapy, either by mouth or by vagina, to obviate the annoying symptoms which may follow. This is particularly true of the woman who is awakened at night by so severe a hot flash or flush that she finds herself drenched with perspiration, or the woman

who has so severe an atrophic vaginitis that it is a constant source of discomfort and annoyance.

In this day when the patient is very likely to bring to her physician impressions gained from the last issue of some publication, the pressure is great to use "shots" of hormones, just as it is to give penicillin at the slightest provocation, in order to be one up on the patient, if you will.

Dr. Hall's paper, already referred to, was read before a session of the Connecticut Academy of General Practice. It should be required reading for every general practitioner in Connecticut who was not in attendance at that particular annual scientific assembly. No truer words have been spoken than those appearing in his first sentence: "The use of hormones has frequently become abuse."

Retirement

"Much of the popular thinking about the deterioration of abilities with age simply does not rest on established fact. Many older workers who have maintained an active interest in a subject for many years are able to draw on an accumulation of personal knowledge and experience, which is not a part of the background of the younger worker."*

We hear much today about retirement at various ages. In many enterprises this is compulsory, in others, elective only to be followed in a few years by a compulsory requirement. One of the principal arguments advanced for such a provision is the fact that it permits an opportunity for the advancement of younger men. Self employed individuals may elect to retire at any age but, unless they maintain an active interest in the guild of which they are a member, their absence from the council chambers serves as a definite loss in the contribution of experience and judgment gained over a period of years.

With the continuing advance in life expectancy there has developed an increasing interest in the problems of the aging. Research is being carried on at this time to determine with what mental poise the industrialist and the professional man meets and utilizes his period of retirement. Figures have already been arrived at to show that he is not such an unhappy, ill adjusted individual as it was predicted he would be. The reasons for this may not be so difficult to analyze. If in his earlier active years he is prevailed upon to accept an administrative post on

the basis of outstanding achievement, all his attention will be consumed in supervising the work of others with a definite shortening of the span of years when he should be putting into practice his own constructive ideas. This individual will arrive at the age of retirement lacking in the personal experiences of life which would enhance his value as a counselor.

On the other hand, the individual who has enjoyed the formative years of his life in doing and has gradually progressed to that stage of administrator which belongs to the later years of middle life, finds himself at the age of retirement a valuable member of society. In this sequence of events he should have found time to develop his hobbies, the *sine qua non* for a happy period of retirement.

All this adds up to one thing, viz., that retirement requires preparation which, if properly developed, should represent a period in life of happiness and satisfaction. There should be no fixed chronological age for such, but rather it should depend on the residual physical and mental capacity of the individual and his ability to utilize the golden age period to his own satisfaction and the joy of his circle of friends.

There is nothing in this world more pitiable than the man or woman who has been forced into retirement, finds nothing of interest in life, and becomes hypochondrical and a problem to the family.

Gentleman From Virginia

The news that Bill Holloway is retiring from the legal staff of the American Medical Association will be received with concern by his many friends in state medical society and medical examining board administration. The fact that he is going to return to Virginia, the land of his birth and lead the life of a country gentleman takes some of the regret out of the change, but his helpful advice will be missed by us.

There are many parts of the Connecticut Medical Practice Act, as it was revised in 1941, that are the product of Mr. Holloway's unequalled knowledge and his skillful pen. He could always give clear and sensible answers to legal questions that seemed complicated to medical minds and his influence through the quarter of a century that he was with the Association will long be appreciated by those he helped so generously.

*Edit., Science, June 3, 1955, page 7A.

Lung Cancer

IN the early years of the twentieth century the diagnosis of lung cancer was a rare event. In fact, deaths were so infrequently attributed to cancer of the entire respiratory system that it was not identified separately in United States mortality statistics until as late as 1914. The rapid rise in lung cancer mortality during the past two decades has now become a matter of grave concern to the medical profession and the public. In 1930, less than 3,000 of almost 1,500,000 deaths in the United States were ascribed to lung cancer; preliminary statistics for 1953 indicate that of the same total number of deaths, about 22,000 were attributed to this disease. It has now become the leading site for cancer mortality among males. The explosive nature of the change in mortality is most unusual for a so-called chronic disease; such a pattern has never been observed for cancer of other sites.

This phenomenon has not been confined to the United States. On reviewing the evidence, Dorn concluded, "Today one can fairly say that cancer of the lung exists as a pandemic disease in North America and in the industrialized countries of Northwest Europe." A Danish investigator, Clemmesen, described the increase in the absolute incidence of lung cancer as "the most violent phenomenon in the history of cancer." The United States is not even in the front rank of countries with high mortality rates. Dunn, in examining the data for fourteen countries with well developed vital statistics systems, found that the United States ranked seventh in lung cancer mortality. The dubious distinction of first place must be accorded to England and Wales. The evidence for an increase rests principally on, but is not confined to, data supplied by vital statistics offices. Doll has reviewed several necropsy studies which support this finding. Hueper, dealing with similar evidence, claimed that the increase started long prior to its reflection in mortality statistics.

Only one-twentieth of the recorded increase in lung cancer mortality in the United States between 1930 and 1950 can be assigned to the aging of the population, associated in part with the reduction in mortality from other causes. Another portion of the increase is due unquestionably to improvements in

diagnosis. However, the consensus among leading investigators, in the words of the Louvain Symposium on the Endemiology of Cancer of the Lung, is that "a significant part of this increase is absolute and represents a real increase in the number of people suffering from primary cancer of the lung." A few dissenters remain, who hold that the recorded increase is purely fictitious. The observations incompatible with the sole explanation of improvement in diagnosis have recently been summarized by Dunn:

- (1) The disproportionate gap in mortality between the two sexes, the increase in the rates for males far outstripping those for females;
- (2) The variation in rates of increase when examined by age groups;
- (3) The magnitude of the current, continuing increase, admittedly without commensurate improvement in diagnostic facilities and techniques.

There is every reason to believe that, although there has been some slackening of the rate of increase, lung cancer mortality will continue to increase in the foreseeable future. When the experience of cohorts (persons born in the same year or group of years) born around 1870, 1880, 1890, and so forth, is traced, it is found that lung cancer mortality begins to play a significant role around age 40 and increases in magnitude thereafter. Furthermore, each succeeding (younger) cohort has experienced increased mortality from this cause. Conservative projections of present trends suggest, for example, that by 1980 the death rate per 100,000 for white males 65 to 74 years will be 215 contrasted to the figure of 105 observed for 1950. On the basis of rates projected in this manner, the "betting odds" are about 4.3 in 100 that a white male between 30 and 50 years of age will develop lung cancer sometime during his life.

Of the several general factors known to govern cancer risk, it is difficult to believe that changes in the genetic composition of the population could have occurred in sufficient magnitude to account for the increase. This leaves a variety of environmental factors as possible causes of the phenomenon. Since abundant animal and human evidence suggests a long latent period between exposure to a carcinoma and disease development, attention has been directed to environmental changes which occurred 15 to 25 years prior to the increase.

The possible environmental changes, not mutually

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exclusive, which have been suggested as causal factors, fall into three major categories:

- (1) Increase in use of tobacco;
- (2) Increased atmospheric pollution by the effluents of an industrial civilization, such as motor vehicle exhausts, products of tarred roads, factory wastes, and so forth;
- (3) Increase in special occupational hazards involving industrial exposure in producing or processing chromate ores, illuminating gas, radioactive ores, and a variety of other substances.

The existence of special occupational hazards cannot be doubted. However, the employee groups are numerically insignificant and this class of risks cannot possibly account for any but a very small part of the observed increase. The atmospheric pollution theory relies mainly on urban-rural differentials in mortality, plus the demonstration in urban atmosphere of substances which are carcinogenic to animals. Such agents were extracted from the atmosphere as early as 1942, and recently Kotin has identified 3,4 benzpyrene, a proved laboratory animal carcinogen, in motor vehicle exhaust gases. Inability to classify the population by degree of exposure to atmospheric pollution and to compute attack rates for groups of people with varying exposure has been a major deterrent in testing the hypothesis of atmospheric pollution as a cause of this disease.

The evidence linking tobacco smoking to lung cancer is much more convincing. At least thirteen retrospective studies conducted during the past fifteen years in five different countries, comparing smoking history in diagnosed lung cancer cases with that from a variety of controls, have uniformly concluded that the risk of lung cancer among smokers exceeds that among nonsmokers. Relative risks for smokers compared to nonsmokers have ranged from about two to fourteen times in the different investigations. These studies incriminate cigarette smoking to a stronger degree than cigar or pipe smoking.

Cutler and Loveland have summarized the results of three sets of these recent investigations in terms of cases of lung cancer expected to develop before age 80 among 1,000 white men now 40 years of age: nonsmokers, 6; one-half pack or less daily, 25; one-half pack to one pack, 49; more than one pack, 80.

Preliminary results from a forward-looking study among smokers and nonsmokers recently reported

by Hammond and Horn lend support to these estimates. The findings of the latter authors lead them to assert cause-effect relationship between cigarette smoking and lung cancer. They obviously cannot claim it as the sole cause, however, since the disease occurs, although less frequently, in nonsmokers. Even prior to this study few workers had seriously questioned the statistical association between lung cancer and smoking, particularly cigarette smoking, or that the association is in general proportional to total tobacco consumption. Controversy revolves around whether this association represents a cause-effect relationship or whether smoking is associated in some undetermined way with other unidentified factors. The issue of association with other factors cannot be resolved in the form of a clinical trial in which exposure to tobacco smoke is assigned in advance, since smoking histories must be accepted as found in the population. The conclusions of the Standing Advisory Committee on Cancer and Radiotherapy to the British Minister of Health summarize one body of prevailing opinion.

"(1) It must be regarded as established that there is a relationship between smoking and cancer of the lung.

"(2) Though there is a strong presumption that the relationship is causal, there is evidence that the relationship is not a simple one, since:

"(a) The evidence in support of presence in tobacco smoke of a carcinogenic agent causing cancer of the lung is not yet certain;

"(b) The statistical evidence indicates that it is unlikely that the increase in the incidence of cancer of the lung is due entirely to increases in smoking;

"(c) The difference in incidence between urban and rural areas and between different towns, suggests that other factors may be operating, e.g., atmospheric pollution, occupational risks."

This position could be modified by new evidence. For example, the American Cancer Society and the National Cancer Institute (in cooperation with the Veterans Administration) are each conducting a forward-looking study of mortality among male smokers and nonsmokers. Here smokers and nonsmokers can be classified with respect to place of residence, occupational history, and possibly other variables. If it is found that the relationship between cigarette smoking and lung cancer holds consistently within a variety of subgroups, the case for cause-effect relationship will be greatly strengthened.

PROGRESS IN CLINICAL MEDICINE

CARDIAC CATHETERIZATION IN DIAGNOSIS

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CARDIAC catheterization has proved to be valuable as an aid in the diagnosis of cardiac malformations and as a research technique for the study of circulatory physiology. The purpose of this report is to describe the technique as it has been applied in cardiac diagnosis of adults and children.

Forssmann¹ became the first person to apply cardiac catheterization to humans by carrying out the procedure on himself in 1929. It was primarily through the work of Cournand and Ranges² in this country that the procedure gained wide acceptance as a feasible diagnostic method for humans. As a result of their studies and those of Bing,³ Dexter⁴ and others^{5,6} cardiac catheterization has been employed many thousands of times in cardiac diagnosis.

DESCRIPTION OF THE TECHNIQUE OF CARDIAC CATHETERIZATION

Cardiac catheterization is quite easily performed on adults and older children. A radio-opaque catheter, similar to that used for retrograde pyelography, but with a curved tip, is passed into a medial antecubital vein through a cut-down incision. Heparinized saline from a bottle approximately eight feet above the floor is dripped slowly through the catheter to maintain patency. The catheter is advanced periodically until it enters the right atrium. Fluoroscopic guidance is needed for passage of the catheter through the right atrium and right ventricle to the pulmonary artery. Samples and pressures are not taken usually until the catheter tip has been passed into one of the main branches of the pulmonary artery. Cautious withdrawal of the catheter with accurate localization by fluoroscopy of the catheter tip enables the operator to obtain serial samples from the right and left pulmonary arteries, the main pulmonary artery, the right ventricle outflow tract, the mid right ventricle, the right ventricle inflow region, from high and low locations in the right atrium, and the superior vena cava. A femoral artery sample and pressure may be taken after the catheterization has been completed, but is more representative if taken at the same time as the right ventricular or pulmonary artery sample. Pressures are obtained by attachment of the distal end of the catheter to a pressure recording system, such as a strain gage unit which converts the pressure pulse into electrical forces which can be recorded by an electrocardiograph. The blood samples are obtained, after the catheter has been cleared of saline, by anaerobic collection of 2 to 5 cc. of blood for chemical analysis of oxygen content. A whole blood oximeter may be used to give approximate values for the oxygen content which may aid the operator in patterning the procedure after the individual patient's needs.⁷

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SUMMARY

The technique of cardiac catheterization as it has been applied to cardiac diagnosis of children and adults is discussed.

Interpretation of the data obtained by cardiac catheterization is reviewed.

The dangers of the procedure and difficulties in interpretation of results are outlined and would indicate the necessity of extensive training of the members of the cardiac diagnostic team.

The changing indications for the procedure in cardiac diagnosis are enumerated in relation to the experience of the cardiac surgical team at the Grace-New Haven Community Hospital.

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The choice of anesthetic and sedative agents varies with the age of the patient and the particular cardiac diagnostic team. Morphine in the usual preanesthetic dose has been effective in most of the patients studied by the pediatric service of the Grace-New

Haven Community Hospital, but we have not combined this with scopolamine or atropine because of the effects that these drugs have on the circulation. Some children above eight years of age have been given intravenous pentothal anesthesia if they are frightened by the diagnostic procedure. Most children below eight years of age have been given rectal and intravenous pentothal anesthesia as well as a 50-50 mixture of nitrous oxide-oxygen. Nitrous oxide anesthesia has been restricted to the period of the surgical cutdown and must be followed by a time interval of at least 20 minutes before the first blood sample is obtained for oxygen analysis. No anesthesia is usually given to adults.

During the procedure the pulse beat is carefully monitored, often by oscillographic recording. Because irregularities are encountered frequently as the catheter passes into and through the right ventricle, the catheter tip should be kept in the right ventricle for as short a period as possible. These irregularities, usually ectopic ventricular and nodal beats, may be prevented in part by the use of prophylactic procaine amide or quinidine.

The application of cardiac catheterization to infant diagnosis is limited by its dangers and the difficulty of obtaining complete studies. Despite these problems, the method can be satisfactorily performed in approximately 75 per cent of cases. We have preferred to use the saphenous approach and have limited anesthesia to local novocain infiltration where possible. A small catheter (number 5 or 6) may be safely introduced into the right atrium by this route without fear of air embolism, but manipulation of the catheter through the right ventricle to the pulmonary artery often has been difficult to perform.

INTERPRETATIONS OF RESULTS

The information obtained from cardiac catheterization consists of (1) the oxygen content and saturation of blood from the sites that are sampled, (2) the blood pressures at the various sites, and (3) the course the catheter follows.

By study of the information obtained from cardiac catheterization of a patient and comparison with the normal values for patients of similar age, an accurate anatomic diagnosis can often be made. The normal values for pressures, oxygen contents and oxygen saturation in the various cardiac chambers and great vessels are shown diagrammatically in Figure 1. Since there is great variation in the oxygen

saturation of the venous blood of different individuals, a large range exists and the absolute value of venous blood oxygen saturation in the right atrium, right ventricle, or pulmonary artery is less important than the similarity between the venous blood samples from these sites. In a normal individual there should be not more than a one volume per cent difference between the oxygen content of the right atrium and right ventricle or between the right ventricle and pulmonary artery as determined by the usual laboratory chemical methods. The difference between superior vena cava and right atrium also should be not greater than two volumes per cent when single samples are compared. Any increase in oxygen content of greater than the above

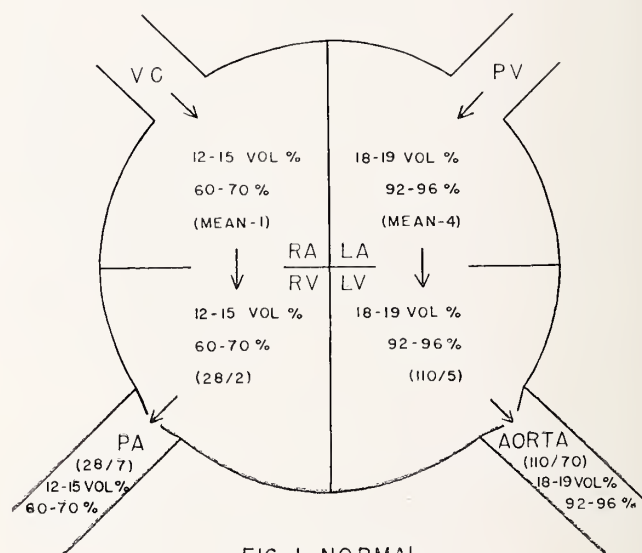


FIG. 1 NORMAL

between one of the sites mentioned and that in the site distal to it will reflect shunting of blood from the left circulation to the right. To illustrate this, let us assume that samples taken from the superior vena cava and inferior vena cava reveal oxygen contents of 13 volumes per cent and that samples from the right atrium reveal oxygen contents of 17 volumes per cent, as do samples from the right ventricle and pulmonary artery. The increase in oxygen content from the venae cavae samples and those in the right atrium is four volumes per cent, which is considerably above normal for the increment between these sites of two volumes per cent. Obviously, much highly oxygenated blood must be intermingling with the venous blood in the right atrium. This could only be explained by the presence of a large atrial septal defect with shunting of blood from the left atrium to right atrium through the septal

defect (as shown in Figure 2) or possibly by abnormal return of pulmonary venous blood through an anomalous pulmonary vein emptying into the right atrium. By similar examples it is possible to show the expected increments for ventricular septal defect and patent ductus arteriosus. Where atrial septal

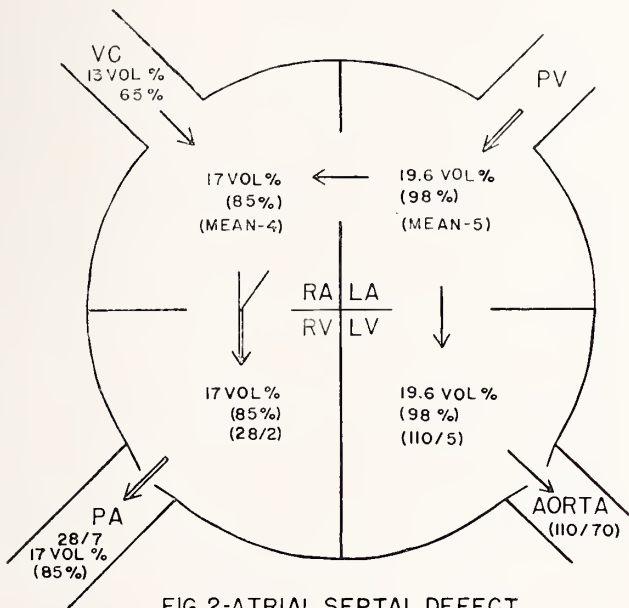


FIG. 2-ATRIAL SEPTAL DEFECT

defect, ventricular septal defect, or patent ductus arteriosus exist as a single lesion, the presence of higher pressure in the left circulation produces shunting from left to right circulation through these abnormal communications.

To illustrate the manner in which pressure measurements may aid in the diagnosis of certain congenital defects, let us assume that valvular pulmonic stenosis exists as the sole lesion (as illustrated in Figure 3). Distal to the obstruction in the pulmonary artery the pressure will be lower than normal. Proximal, however, the right ventricular pressure will be very much elevated as a result of the “damming” effect that has taken place. If the tricuspid valve is not insufficient, pressures in the right atrium and venae cavae will be normal. If on the other hand this valve is insufficient, the increased pressure in the right ventricle will be transmitted back into the right atrium and the venous pressure likewise will be increased. A particularly dramatic demonstration of pulmonic stenosis may be obtained by taking a continuous pressure recording as the cardiac catheter tip is withdrawn from the pulmonary artery through the valve to the right ventricle outflow tract. By simultaneous fluoroscopy the approximate location of the stenosis can be delineated and an impression gained as to the type of stenosis, valvular or sub-

valvular (infundibular). This information may be of great value to the surgeon as he plans the valvulotomy operation.⁸

The catheter may be passed into unusual locations and may demonstrate certain unsuspected abnormalities. Passage from the right atrium into a pulmonary vein draining anomalously directly into the right atrium is often accomplished. Another frequently encountered anomaly in patients with congenital heart disease is that of a persistent left superior vena cava draining into the coronary sinus, an abnormality which will be demonstrated at times in those patients catheterized through the left arm veins. Deliberate passage of a cardiac catheter from pulmonary artery through a patent ductus arteriosus into the aorta may demonstrate the existence of this remedial defect.

DANGERS AND LIMITATIONS

Cardiac catheterization is not without risk, even when used for patients who are in good condition. Deaths have been reported which are usually a result of ventricular fibrillation or cardiac arrest during the intracardiac manipulation of the catheter. Arrhythmias most frequently occur as the catheter is passed through the tricuspid valve into the right ventricle and through the right ventricular outflow tract. Careful monitoring of the pulse is necessary

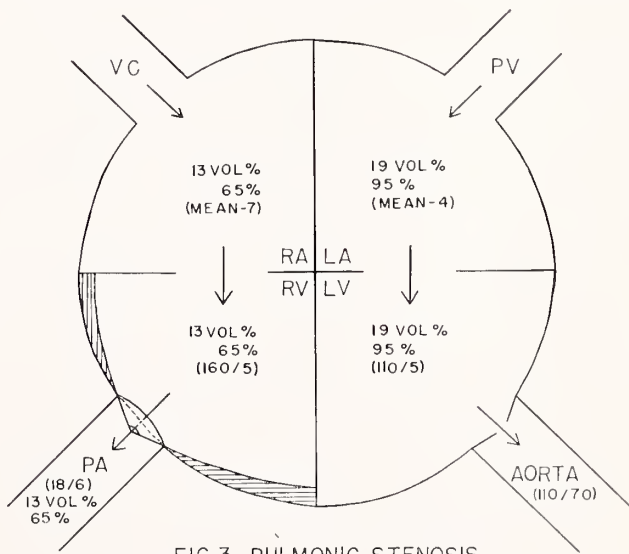


FIG. 3-PULMONIC STENOSIS

and many cardiologists have stated the importance of visually recording the electrocardiograph by oscillography or direct-writing electrocardiograph during the intracardiac manipulation. The appearance of threatening arrhythmias necessitates the immediate withdrawal of the catheter tip to the superior vena cava and persistent arrhythmia neces-

sitates the cessation of the procedure. The procedure has proven more dangerous when applied to infants, especially those with cardiac decompensation or those on digitalis. The overall mortality rate in adults would appear to be approximately 0.1 per cent and in infants below 18 months approximately 1.7 per cent.⁹ Certain congenital cardiac conditions have been associated with particularly high mortality rates and most authors believe that the procedure is specifically contra-indicated in cases of Ebstein's anomaly. This rare malformation is characterized by displacement of the tricuspid valve into the right ventricle with great enlargement of the right atrium and a pronounced tendency to development of severe auricular arrhythmias.

In addition to its dangers the procedure of cardiac catheterization has serious limitations, as do all laboratory procedures. At times the test cannot be completed satisfactorily with the result that fragmentary information is obtained. Also occasionally the data may show equivocal findings which may suggest the diagnosis but not fulfill the usually accepted criteria for diagnosis. Variations in the patient's basal state and technical difficulties in recording accurate pressures occur.

As should be obvious from the above discussion, because of the intricacies, dangers and difficulties of interpretation of results of the procedure, its use should be limited to a well trained team of cardiologists or surgeons. The use of resident physicians or other physicians whose interest in the procedure is casual as the principal operator or interpreter of results must be strongly condemned. At least one physician extensively trained in the use of the technique must be present during the procedure.

The results of cardiac catheterization of patients on whom surgical procedure is contemplated must be interpreted and discussed in detail with the cardiac surgeon and his assistants. All of the cases studied by the departments of pediatric cardiology and cardiology of the Yale-New Haven Medical Center have been presented in a conference attended by the cardiac surgeon in chief, Dr. William W. L. Glenn, and representatives of the radiology department. Accurate preoperative diagnosis of the congenital malformations of the heart by cardiac catheterization enables the surgeon to plan his operation optimally and strongly improves the outlook for success.

INDICATIONS FOR THE USE OF CARDIAC CATHETERIZATION

As the procedure of cardiac catheterization has become more widely employed by diagnostic labor-

atories and as the information gained from its use has greatly clarified our knowledge of the circulation through the right heart and pulmonary arteries, the indications for its use have changed. Because investigators in research laboratories have performed a variety of experiments determining the circulatory dynamics of normal individuals at rest and with exercise, of individuals with pulmonary disease, and of individuals with acquired and congenital heart disease, the laboratory oriented to diagnosis should limit itself primarily to the study of patients with those types of cardiac disease probably amenable to surgical repair. Also the clinical diagnosis of cardiac malformations, especially those of congenital etiology, has become far more refined as a result of the development of unipolar electrocardiography and improved interpretation of physical findings and standard x-rays. Many of the congenital malformations that were puzzling diagnostic problems to the clinician five years ago and required cardiac catheterization for accurate definition can now be accurately diagnosed without resort to this technique. Lastly, angiocardiology has been greatly developed during the last five years and may now be used to provide information of diagnostic importance so as to preclude the necessity of using the more difficult method of cardiac catheterization.

As a result of experience with the performance of 180 cardiac catheterizations in our laboratories since 1950, certain criteria for the selection of patients for cardiac catheterization as a diagnostic technique have evolved.

(1) PATIENTS WITH CONGENITAL CARDIAC MALFORMATIONS PROBABLY REQUIRING REPAIR BY CARDIAC SURGERY

This group of patients includes the most important group of cardiac disorders where study by cardiac catheterization is indicated. For some of these patients the cardiac catheterization is performed electively to verify a diagnosis strongly suspected after clinical study. For others the cardiac catheterization is performed as an urgent procedure in the hope of demonstrating a surgically correctable lesion in a desperately ill patient.

(A) Pulmonic stenosis. All patients with pulmonic stenosis, including those with tetralogy of Fallot, are considered candidates for cardiac catheterization at our hospital. The cardiac catheterization of these patients has revealed increased right ventricular pressure consistently and, when the catheter has been introduced safely into the pulmonary artery, has shown the pulmonic stenosis. Demonstration of

right ventricular pressures greatly in excess of simultaneously determined femoral arterial pressures has been associated with pulmonic stenosis without ventricular septal defect, a condition which must be corrected surgically by a direct attack on the stenosis. Angiocardiography may be used as an alternate diagnostic test in patients with pulmonic stenosis, but in our experience has been more valuable as a supplementary test. The information gained from both studies in pulmonic stenosis patients is the most complete that can be offered to the surgeon.

(B) Atrial septal defects. Severely incapacitated patients with probable atrial septal defect clinically have been studied by cardiac catheterization for verification of diagnosis and estimation of the size of the shunting of blood through the atrial defect.

(C) Arterio-venous shunts with possible patent ductus arteriosus. Typical cases of patent ductus arteriosus need not be subjected to cardiac catheterization prior to operation. The presence of other cardiac lesions or of pulmonary hypertension in children and adults may obscure the characteristic features and make cardiac catheterization necessary for diagnosis. We have limited the use of cardiac catheterization for those patients with severe disability who might be benefited greatly by surgical correction of a discovered patent ductus. Infants with patent ductus may not show the typical finding of a continuous basilar murmur. Although cardiac catheterization is more dangerous in infants than in adults, it should not be withheld from the infant with evidence of arteriovenous shunting of blood and cardiac failure whose clinical findings are compatible with the diagnosis of patent ductus arteriosus, despite the absence of a continuous basilar murmur.

(2) PATIENTS WITH ACQUIRED CARDIAC MALFORMATIONS PROBABLY REQUIRING OPERATION

Cardiac catheterization of patients with acquired malformations of the heart is rarely indicated during childhood. Because rheumatic heart disease involves the mitral and aortic valves which are inaccessible to the cardiac catheter, the information obtained is limited. Although pressures suggesting those in the left auricle may be obtained with the catheter wedged into the pulmonary artery, the data obtained by this technique have not consistently predicted the severity of mitral stenosis or insufficiency. Pulmonary arterial hypertension which can be demonstrated by cardiac catheterization is more often associated with severe rheumatic mitral stenosis than with severe mitral insufficiency. At this hospital patients with mitral stenosis considered for commis-

surotomy are rarely studied by cardiac catheterization.

(3) PATIENTS WITH CONGENITAL MALFORMATIONS WHOSE DIAGNOSIS IS OBSCURE

Rarely, cardiac catheterization may be indicated for the establishment of a diagnosis in a patient where the possibility of operation is remote. Perhaps one out of every 20 patients studied by cardiac catheterization at this hospital might fit into this group. Patients suspected of having anomalies of pulmonary venous return, of combined ventricular septal defects, or of atrioventricularis communis have been studied because the clinical diagnostic features of these malformations have not been clearly defined.

Angiocardiography has been used as the procedure of choice in the diagnosis of most cases of congenital heart disease characterized by venoarterial shunting. All cases of suspected tricuspid atresia, transposition of the great vessels, single ventricle, and truncus arteriosus who appear able to tolerate the procedure should be studied by this method.

The preparation of this report was aided by grants from the Stanford Heart Association and from the Victoria Fund.

The author is indebted to Miss Dorothy Nixon and to Mrs. Patricia Leoni for aid in the preparation of the manuscript.

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THE PRESIDENT'S PAGE

NESTLING on the side hill, located at the corner of St. Ronan and Edwards Street, is a white, flat-top building. Its simple dignity is in keeping with the requirements for the ideal home of the Connecticut State Medical Society. Inside its floor space is arranged to meet the peculiar needs of our activities. Besides the offices of our Executive Secretary, our Medical Journal, the Public Relations Department and committee meetings rooms, it also houses the offices of the Connecticut Hospital Association, Connecticut Medical Examining Board and the Advisory Committee to Selective Service. At the present time we have outgrown these facilities and need a larger meeting room and more office space. It is interesting to review the steps taken by your Society, making this central office possible. Briefly, they are as follows:

During the war years it became apparent we must have our own home. Dr. J. Douglas Gold became the chairman of our committee to study the problem, make recommendations for its location and suggest various methods of its financing. We owe a lot to this committee for the careful and intelligent approach they made to this complex problem. Should its location be in Hartford, the State Capital, with its Health Department and other state activities, as well as being the geographical center; or should it be in New Haven, the population center, with its traditional medical leadership? New Haven was selected.

Selection of the site and type of building required, involved much debate and clear thinking. A survey of available buildings convinced us we should build, rather than remodel.

During this period, various methods of financing our office were studied and it was unanimously decided to finance it by voluntary contributions from our members. As a result of this campaign, \$81,980 was raised. Of our 2,510 members, 1,171 contributed an average of \$60.90, for a total of \$71,290. The balance of \$10,690 was contributed as Special and Memorial Gifts.

Ground for the building was broken on March 14, 1949 and our staff moved into the building permanently on August 25, 1949. The land and building is ours, completely free of any indebtedness.

Oliver L. Stringfield, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

JAMES G. BURCH
Director of Public Relations

JOSEPHINE P. LINDQUIST
Administrative Assistant

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SCHOLARSHIPS FOR MEDICAL STUDENTS

The Society will offer a number of scholarships of Five Hundred Dollars each for the academic year 1955-56 to students who are in their final year in an approved medical school in the United States or Canada and whose homes are in the State of Connecticut.

Information concerning these scholarships can be obtained from the secretary's office and applications should be submitted before November 15, 1955.

New Doctor Draft Act

The 84th Congress renewed the Doctor Draft Law which would have expired on June 30, Public Law 118, replacing Public Law 84.

The Doctor Draft provisions were extended to July 1, 1957 although the Universal Military Training and Service Act was extended to July 1, 1959.

There are important new features for physicians. The last sentence of section 4 (i) (1) of the Act provides:

Liability for military service for physicians under the amended Act is removed if the physician has passed his thirty-fifth birthday and has previously been rejected for a commission on the ground of physical disqualification and, the cut-off date for liability is the forty-sixth birthday instead of the fifty-first birthday which has been in the law since 1950.

Draft Eligible Physicians To Be Reexamined

Physicians in certain categories who have not been examined by their local draft boards since August 1, 1954, will soon receive notices to report for reexamination.

Those affected are: 1-A physicians in Priorities I and II who will not reach age 46 in 1955 and 1-A physicians in Priority III who were born on or after January 1, 1917.

This checkup, according to the Washington Re-

port on the Medical Sciences, is indicative of an Army callup early in 1956.

From the Commissioner of Welfare

The tremendous rise in the cost of our Welfare medical care program, some 37 per cent increase in a single year, has necessitated an inquiry into its cause and a search for all possible means of controlling this very large item in our budget.

We note with satisfaction that our medical care program is one of the most complete and progressive in the country. But we cannot justify maintenance of this enviable position through an unwarranted burden on our taxpayers, many of whom could ill afford the generous services available to Welfare beneficiaries.

By statute we can pay for any medical care which is "necessary and reasonable," but for nothing which is "merely desirable or convenient." This implies a policy of providing strictly necessary medical care on the basis of an adequate minimum; that is, standard accepted methods of diagnosis and treatment only.

Implementing these statutory requirements are the regulations issued by the Commissioner of Finance and Control which govern payment by all State agencies, and those of our Welfare Department which have been compiled with the cooperation, advice and approval of representative committees of the various professional and other associations concerned. These regulations express our general policy,

and have the acceptance of the practitioners, pharmacists and vendors who serve our beneficiaries.

We do not wish to depart from the principles of free choice and total medical care which underlie our program today, nor to set arbitrary limits to services and expenditures if we can avoid it. Therefore, as a less drastic approach to our necessary task of cutting medical costs we propose a trial of strict enforcement of the rules and regulations now on the books, all of which have been issued to you over the past several years.

Hence, effective this date, the statutes and all regulations governing the medical care program of the Connecticut State Welfare Department will be strictly enforced.

There will be no exceptions, apart from acute humanitarian considerations, and any such rare deviation will be reviewed by the Commissioner of Welfare personally.

In behalf of Connecticut's taxpayers I earnestly request your full cooperation in this effort to serve their interests.

Interesting Position Open

The post of Assistant Ships Doctor for a Deluxe 'round the world cruise is available. New luxury liner, foreign registry. Leaves New York early January for ninety-seven days. Salary and all expenses. Details from the Secretary's office, telephone UN 5-0587, New Haven.

Meetings Held During August

- August 2—Committee on Arrangements for 1956 Annual Meeting
- August 10—Medical Advisory Committee to the State Welfare Department
- August 10—Conference Committee with Connecticut Pharmaceutical Association
- August 18—Subcommittee on School Health
- August 22—Symposium on Industrial Health

THE DOCTOR'S OFFICE

Robert J. Alesbury, M.D. announces the opening of an office for the practice of obstetrics and gynecology at 139 East Center Street, Manchester.

William J. Beard, M.D. announces the opening of an office for the general practice of medicine at 1778 East Main Street, Waterbury.

Roger S. Beck, M.D. announces the opening of an office for the practice of surgery at 150 Jefferson Street, Hartford.

Ronald Coe, M.D. announces the opening of an office for the practice of internal medicine at 1727 Whitney Avenue, Hamden.

William D. Irving, M.D. announces the opening of an office for the practice of pediatrics on Main Street, Old Saybrook.

Paul F. McAlenney, M.D. announces the removal of his office to 1435 Chapel Street, New Haven.

Walter S. Morgan, M.D. announces the opening of an office for the practice of internal medicine at 1876 Whitney Avenue, Hamden.

Seymour H. Saltzman, M.D. announces the opening of an office for the practice of internal medicine at 581 Farmington Avenue, Hartford.

William R. Stevenson, M.D. announces the opening of an office for the practice of general surgery at 122 Maple Street, Bristol.

Second Amendment to Embargo on Poliomyelitis Vaccine

Under the authority of Public Act 133, January Session, 1955 and the Temporary Rules and Regulations of the State Department of Health promulgated thereunder, the Deputy Commissioner of Health hereby amends the embargo of May 10, 1955, and the amendment to the embargo of May 16, 1955, releasing vaccine manufactured by Wyeth, Incorporated.

Vaccine made by all other manufacturers with the exception of Parke-Davis Company and Eli Lilly and Company, previously released, will remain under embargo until the State Department of Health receives information from the Public Health Service that their product has fully met the requirements of the Biologics Control Laboratory of the National Institutes of Health for purity, potency, and safety.

Dated at Hartford, Connecticut, this 9th day of August, 1955.

Harold S. Barrett, M.D.

THE HISTORIAN'S NOTE BOOK

ABSCCESS OF THE HIP JOINT

Its Symptoms and Cure According to W. P. Dewees, M. D., (1768-1841)

ARTHUR S. BRACKETT, M.D., *Riverside*

THE popularity of "A Treatise on the Physical and Medical Treatment of Children" is shown by the fact that there were seven editions published after the death of the author, William P. Dewees, M.D. in 1841. The following is from the tenth edition, 1853, published by Blanchard and Lea, Philadelphia, chapter XX, pages 311-314.

"The commencement of inflammation in the hip joint is not perceived as early as would be useful to the patient . . . This complaint is most frequent with children . . . Even after the disease has progressed some time, and an evident weakness is observed in the limb, by its being favored at the expense of the other; when pain is felt from motion, and there is a disposition to fall from slighter causes than usual; and even when the points of the toes look more inward or outward than natural; the true nature of this disease is not suspected, as there is no fixed pain in hip joint, or even upon pretty hard pressure—indeed, the friends of the patient are constantly misled by his declaring he feels no pain except in the knee.

"If the two limbs be compared . . . the diseased one will be found rather longer than the other . . . a limping commences. Though the patient locates his inconvenience in the knee . . . if the sensations of the patient be carefully examined during the motions imposed upon the knee joint, such as bending it, and straightening of it, it will be found he experiences inconvenience in the joint of the hip.

"This . . . inflammation of the hip joint . . . if it be not controlled . . . runs on to suppuration . . . the bones at the bottom of the abscess but too frequently become carious; hectic fever ensues.

"For remedies to be useful in this disease, they should be early applied . . . persevered in, and . . . perfect rest enjoined upon the patient.

"The cure must be attempted by bleeding, leeching, cupping, purging, low diet and rest.

"From pain being seated in the knee, this complaint is always mistaken for rheumatism, or some other local affection of this part.

"To Dr. Physick we are indebted for the proper mode of treating this affection. . . . It was he who first suggested constant purging, and entire rest; and to which this formidable disease so often yields, when tried under proper circumstances. Valuable as this plan is, it must be confessed to be one of difficult execution; but . . . we know it to be successful. Who, then, would hesitate to enforce a plan that might save a lovely female from an incurable lameness, or a favourite son from a lingering death?

"But let us be a little more particular. . . . The child must abstain from all animal food or broths; he must be laid prostrate upon his bed or mattress, . . . exercising the limb . . . as little as possible: he must be bled freely from the arm, if the pulse be active, or leeches upon the hip . . . these must be repeated in proportion to pain, or fever. The bowels must be purged daily . . . by the exhibition of cream of tartar and jalap. . . . Under this apparently weakening plan, it is astonishing, sometimes, to see how health and strength improve. Where it is impossible to confine the patient, much advantage is found from the curved splint, made to fit the hip and thigh . . . Dr. Physick and myself had a very desperate case lately, which required six or seven months to cure. . . . The splint was modelled to the shape of the leg, three times, as it required lengthening during the progress of the cure."

Mrs. J. E. Mack has been of much help in preparing the manuscript for publication.

Rheumatic Fever Prevention Program

In January, 1952 the Committee on Prevention of Rheumatic Fever and Bacterial Endocarditis of the Council on Rheumatic Fever and Congenital Heart Disease of the American Heart Association published a statement based on research indicating that daily doses of penicillin would prevent recurrences of rheumatic fever.

Results of a questionnaire sent to all Connecticut physicians early in 1953 by the Connecticut State Department of Health and the Connecticut Heart Association revealed that Connecticut physicians were overwhelmingly in favor of the use of agents for the prevention of recurrences of rheumatic fever, and that penicillin was the drug of choice. However, questioning of physicians revealed that the relatively high cost of penicillin for prolonged prophylactic use was a most important deterrent to its being prescribed and to its continued use by patients. In view of this the Rheumatic Fever Committee of the Connecticut Heart Association sought to work out a plan to make penicillin for prophylaxis of rheumatic fever more readily available to patients.

Initiated by the Connecticut Heart Association, a Planning Committee for Rheumatic Fever Prophylaxis in Connecticut was formed, composed of representatives of the Connecticut Pharmaceutical Association, wholesale druggists, the Connecticut Heart Association, and the Connecticut State Medical Society. A plan was carefully prepared, endorsed by the Connecticut State Medical Society and the Connecticut State Department of Health and put in operation early in June, 1955. The July 1955 issue of the JOURNAL contained an article giving the details of the program. The same information was sent to every Connecticut physician by the Rheumatic Fever Committee of the Connecticut Heart Association.

The first several months' experience indicates that the plan is meeting a definite need, that of making penicillin more readily available to rheumatic fever patients to prevent recurrent attacks. As of August 1, 365 patients were being served by the program through their physicians.

The wholehearted cooperation of physicians, pharmacists, wholesale druggists and the manufacturer in adhering to the distribution procedures has been most gratifying. Only in a few instances have violations occurred, and in these cases a follow-up

has quickly met with ready willingness to correct the situation.

Since the advent of the sulfonamides and penicillin, rheumatic fever has not presented the widespread problem it was even a decade ago. However, the American Heart Association and its affiliates have long believed that rheumatic fever is one aspect of the total heart disease problem for which something can now be done.

Problems associated with diagnosis and management of rheumatic heart disease still exist. The Rheumatic Fever Committee of the Connecticut Heart Association, composed primarily of physician representatives of local heart chapters throughout the State, is planning to help solve some of these problems through programs of professional education. Similarly, the Rheumatic Fever Committee and the Education Committee of the Connecticut Heart Association will support a conservative program of lay education.

With the cooperation of physicians, pharmacists, laymen and others in the various phases of the total Rheumatic Fever Program, as exemplified in the penicillin procedures, rheumatic heart disease can truly become a preventable disease in Connecticut.

New Medical Director at Meriden Hospital

Paul W. Weld succeeds Donald E. Rowley as medical educational director at the Meriden Hospital.

Dr. Weld will serve in this capacity on Monday, Wednesday and Friday, as did Dr. Rowley, and on the alternate days, will render a similar service to the Bristol Hospital in Bristol, Connecticut.

Dr. Weld is well qualified for his new duties. He comes direct from a Research Fellowship in Medicine at Buffalo General Hospital, Buffalo, New York. He attended Cornell University, Ithaca, New York, where he obtained his B.S. degree, and later received his medical degree at the Yale University School of Medicine. His postgraduate work in medicine was done at the Buffalo General Hospital, Buffalo, New York.

Bridgeport Clinic Service Area Expanded by Veterans Administration

Recently the Hartford Regional Office, Veterans Administration, announced expansion of the Bridgeport clinic service area. This comprised the addition

of the following communities: Seymour, Ansonia, Derby, Orange, Wilton, and Norwalk.

Previously veterans in these communities were not eligible to attend the clinics but under the new arrangement they are now permitted to do so. The action was taken under regulations of the Medical Department of the Veterans Administration which requires periodical re-evaluation of clinic service areas to determine if clinic facilities are being used to reasonable capacity. In addition to changes in service areas, there are a number of other factors which may effect the eligibility of a veteran for treatment of a service connected disability at a VA clinic or by a fee basis physician in his home community.

These factors are set forth in a recent communication from Francis J. Ryan, M.D. chief medical officer, Hartford Regional Office, Veterans Administration as follows:

"1. Veterans requiring frequent medical treatment and who live within a 25 mile radius of the Hartford VA Regional Office Clinic, or the Bridgeport VA Office Clinic, are expected to report to these clinics for treatment.

"2. Veterans outside of these areas who have chronic illnesses that require only occasional follow-up visits (e.g., two to four times per year) are usually expected to report to the VA Clinics.

"3. Certain veteran patients are required by regulation to be followed at a VA Clinic. This pertains, for example, to veterans with pulmonary tuberculosis who are receiving chemotherapy on an ambulatory basis.

"4. The nature of the disability requiring treatment and the availability of adequate professional personnel for its proper management is considered prior to scheduling a veteran at a VA Clinic.

"5. A veteran who lives outside the area normally served by our clinics may voluntarily desire to come to the VA Clinic for medical care rather than seek treatment by his local physician.

"6. Elderly patients, amputees, severe cardiac patients, and others who find it a hardship to travel because of their medical condition are not expected to report to our clinics regardless of proximity to a VA Clinic."

AMA Approves Five New Simplified Insurance Claim Forms

Approval has been granted by the AMA's Council on Medical Service to five new simplified insurance claim forms drawn up by a special committee of the health Insurance Council. This committee which worked in collaboration with the AMA Council's Committee on Prepayment Medical and Hospital Service included representation from all types of private insurance carriers. At the present time, a total of six simplified insurance claim forms have been approved by the American Medical Association.

The additional claim forms may be identified by the following symbols and titles: ID-1—Attending Physician's Statement, Accident or Sickness (Individual Insurance); IDS-1—Attending Physician's Supplementary Statement (Individual Insurance); GD-1—Attending Physician's Statement (Group Insurance); GDS-1—Attending Physician's Supplementary Statement (Group Insurance), and IPHS-1—Attending Physician's Statement, Accident or Sickness (Individual Hospital or Surgical). These five forms together with GS-1 (Group Surgical Expense, approved in 1954) are, in essence, adaptations of two basic forms—one designed for groups and the other for insurance underwritten on an individual or nongroup basis.

It is hoped that the majority of the insurance companies identified with the Health Insurance Council soon will use these forms in their day-to-day claims administration and that physicians throughout the country will cooperate by completing the simplified forms promptly to facilitate the administration of claims.

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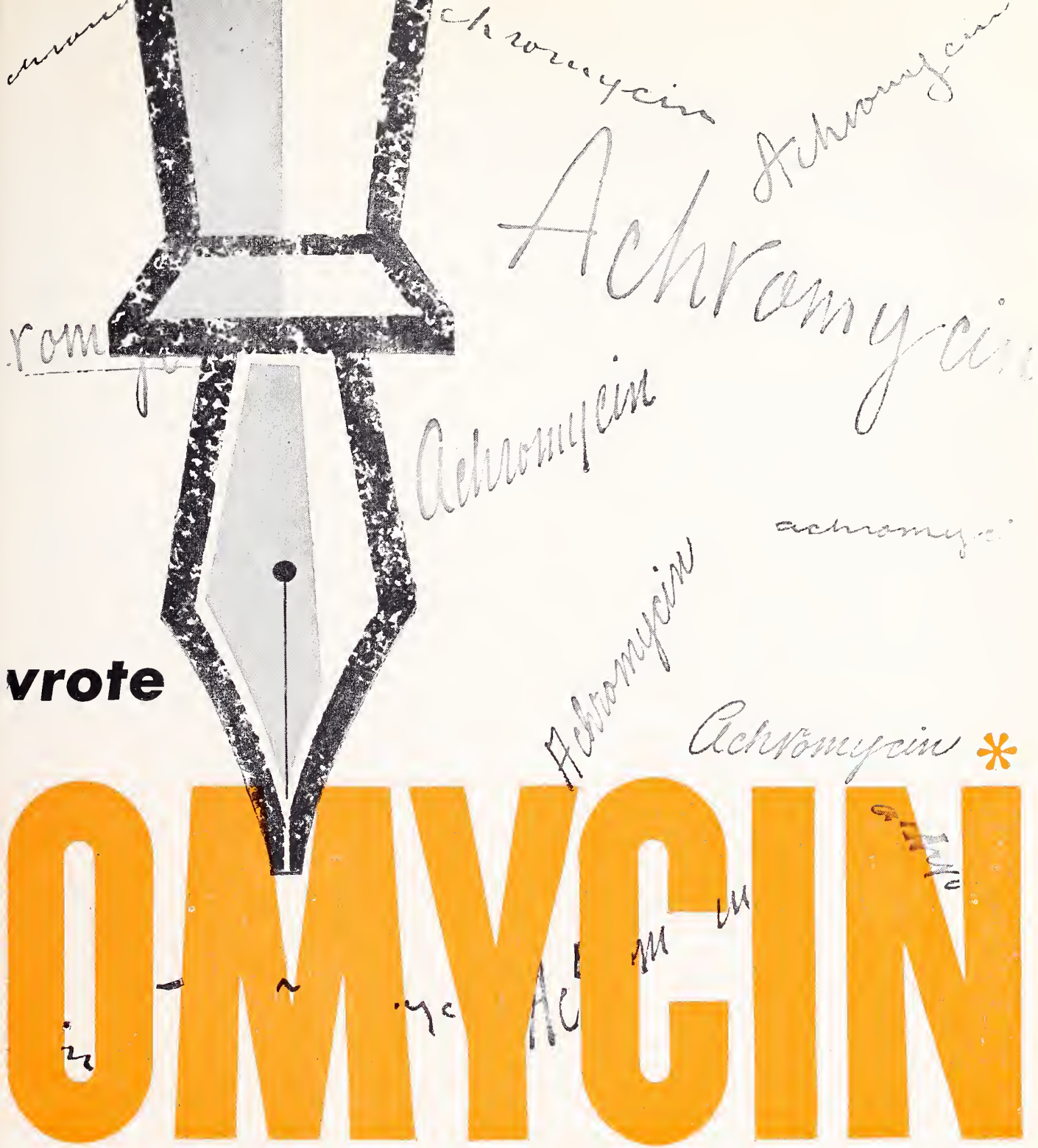
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Special Article

PROFESSIONAL SERVICES INDEX STUDIES A Comparison of Results in Connecticut and Montana

WILLIAM H. HORTON, M.D., *Windsor*

THE results of an experimental study in the development of a professional services index conducted by the Economics Committee of the Montana Medical Association among its membership using the formula developed in previous similar studies in Connecticut are in substantial agreement with the results obtained in Connecticut.

This fact seems particularly significant because the evaluations made independently by the practicing physicians of the two States are in such close agreement despite the extent to which the two States vary on so many economic bases.

Connecticut and Montana show pronounced differences when compared as to size, population, and its distribution and per capita wealth. Montana is 30 times as large as Connecticut and ranks third in geographical area while Connecticut is 46; Montana with approximately 600,000 people is 42nd among the States while Connecticut with something over 2,000,000 is 28; 43 per cent of Montana's population is urban in comparison with 77 per cent of Connecticut; in Montana there are 57 persons per square mile while in Connecticut there are over 400; internal revenue collections in Montana in 1953 were \$122,000,000 and in Connecticut \$1,228,000,000. The per capita income in Connecticut in 1953 was \$2,194, second highest in the country, while in Montana it was \$1,689, nineteenth highest. In summary, Montana represents a typical large State with a predominantly widely dispersed rural population and a basic agriculture-animal industry economy. Connecticut represents a typical small State rather densely populated, predominantly urban community with a highly developed industrial economy.

These differences in the basic nature of the two States are cited to emphasize the importance of the uniformity of the results of these two independent studies. It seems that the physicians residing in the two States find a common ground in the practice of medicine despite the major variations in the econo-

The Author. *Executive Director and Director of Medical Services, Connecticut Medical Service*

SUMMARY

This paper presents a comparison of the results obtained in studies carried out in Montana and Connecticut in the development of a professional services index. The findings of the study to establish a professional services index conducted by the Economics Committee of the Montana Medical Association, by use of the same formula, closely parallel the results of the original Connecticut studies. The report of the Montana studies confirms the conclusions of the Connecticut studies. The substantial agreement of the results arrived at by applying the same formula to the evaluations of practicing physicians in communities with widely differing economic backgrounds indicates that use of the formula is not limited to any particular geographical area of the country. The average professional services index developed by use of the formula on the combined results of identical studies in Connecticut and Montana is in substantial agreement with the professional services index developed by the original Connecticut studies.

mies. The formula appears to disregard the important economic measurements noted above and provides a practical means of developing a professional services index by objective means which will serve the best interests of the physicians and their patients. There are satisfactory explanations for the variations which are noted between the evaluations of the two States and the differences serve more to support rather than discredit the formula.

THE MONTANA STUDIES

The Economics Committee of the Montana Medical Association decided in June, 1954 to conduct a study of their fee schedules based on the

formula used in Connecticut in conjunction with "Studies to Establish a Professional Services Index." Technical materials and procedures used in the Connecticut studies were forwarded to Montana at their request. Five hundred and twelve questionnaires were mailed to all practicing physicians in Montana by the Economics Committee and 61 per cent of the membership responded. After the returns had been tabulated and the formula applied, the following conclusions of the study were made to the House of Delegates of the Montana Medical Association at its annual meeting this year.

"1. There is a disproportion between many items of the MMA Fee Schedule on the basis of the answers received to this questionnaire.

"2. It is definitely possible for practicing physicians to arrange for themselves a Professional Services Index which will establish the correct relationship (in the opinion of the physicians themselves) between widely differing procedures to serve as a framework for the development of fair fee schedules.

"3. It is most probable that medical practice will have to produce a Professional Services Index, or its equivalent, within the next few years; it is certainly better for the profession that the practicing physicians who will render the services, do the job themselves rather than to have it done for them by others who are "third parties" in the physician-patient relationship.

"4. These conclusions parallel the Horton report very closely."

The House of Delegates instructed the Economics Committee to continue its study of the Montana Medical Association fee schedule on the basis of the results of the survey.

The Economics Committee of the Montana Medical Association is currently (July) conducting a study based on the formula with all Montana physicians using 200 surgical procedures in addition to the 25 used in the first survey.

THE FORMULA

The identical formula has been applied to the individual evaluations of the physicians of both States. In the original Connecticut studies the allocation of the degrees of the various factors was arrived

at by using the degree which had the greatest number of individual evaluations, *majority selection*. The Montana allocations were based on averaging the individual evaluations, *average selection*. The following example indicates the difference in the two systems.

It does not appear that a professional services index developed by use of the formula will vary significantly regardless of whether *majority selection* or *average selection* of evaluating factors is used.

COMPARISON OF ORIGINAL CONNECTICUT PROFESSIONAL SERVICES INDEX BASED ON MAJORITY SELECTION EVALUATION AND AVERAGE CONNECTICUT-MONTANA PROFESSIONAL SERVICES INDEX DEVELOPED BY AVERAGE SELECTION EVALUATION

	PROFESSIONAL SERVICES INDEX	
	CONNECTICUT (MAJORITY SELECTION)	MONTANA (AVERAGE SELECTION)
Appendectomy	12.0	11.85
Cholecystectomy	18.0	17.10
Hysterectomy, abdominal, total.....	18.0	17.15
Gastrectomy	23.0	21.80
T & A, child.....	6.0	5.95
D & C.....	3.0	3.95
Hemorrhoidectomy, int. and ext.	10.0	10.00
Nephrectomy	18.0	18.85
Cystoscopy with ureteral catheterization	4.0	4.60
Mastectomy:		
Simple	10.0	10.70
Radical	19.0	19.55
Colon resection	23.0	21.25
Fractured femur, closed reduction..	11.0	10.25
Fractured femur, open reduction.....	17.0	15.90
Fractured metatarsal, closed reduction	9.0	7.80
Colles fracture, closed reduction.....	9.0	7.85
Prostatectomy:		
Suprapubic	18.0	17.25
Transurethral	17.0	17.65
Submucous resection	10.0	12.30
Extraction of cataract lens.....	14.0	14.65
Herniorrhaphy, inguinal:		
Unilateral	10.0	10.85
Bilateral	12.0	12.05
Craniotomy, for tumor or abscess....	27.0	25.15
Varicose veins:		
Unilateral	10.0	10.55
Bilateral	11.0	11.40

Original Connecticut Majority Selection System

TECHNICAL SKILL REQUIRED				
MINIMUM INDEX VALUE	AVERAGE INDEX VALUE	ADVANCED INDEX VALUE	MAXIMUM INDEX VALUE	TOTAL
1	2	3	4	
Nephrectomy 3	76	384	203	666

Thus "advanced" which had 58 per cent of the individual evaluations was used as the degree factor for technical skill, Index Value 3.0.

Application of Montana *Average Selection* System to Connecticut Evaluation Above

TECHNICAL SKILL REQUIRED				
MINIMUM INDEX VALUE	AVERAGE INDEX VALUE	ADVANCED INDEX VALUE	MAXIMUM INDEX VALUE	TOTAL
0-1.5	1.6-2.5	2.6-3.5	3.6-4.5	
Nephrectomy $3 \times 1 = 3$	$76 \times 2 = 152$	$384 \times 3 = 1152$	$203 \times 4 = 812$	$2119 \div 666 = \text{Index value } 3.2$

Thus "advanced," with an index value of 3.2, was used as the degree factor for technical skill.

In order that all comparisons in this paper may have identical bases (and since the individual evaluations of the Montana study were not available) all of the original Connecticut studies have been redone using the Montana average selection system.

All evaluations noted hereafter in this paper are the results of using the average selection evaluation rather than the majority selection evaluation.

The following description of the formula is reprinted from the original study (CONNECTICUT STATE MEDICAL JOURNAL, April 1953, Volume XVII, No. 4, page 337) as background information.

THE FORMULA

FACTORS:

INDEX VALUE (MAJORITY SELECTION)	(AVERAGE SELECTION)
--	------------------------

I. Surgical fields (Sf)

A. Instrumentation, not requiring an approach by cutting surgery.....	0	0
B. (a) Superficial lesions, lacerations and wounds		
(b) External organs and tissues....		
(c) Cavities opening externally, directly or indirectly.....	1	1
(d) Extremities		
C. Internal organs and tissues.....	2	2

II. Surgical problem (Sp)

A. (a) Simple incision, excision or repair		
(b) Closed reduction of fractures	1	1
(c) Manipulative endoscopy		

B. (a) Extensive excision, dissection or repair		
(b) Open reduction of fractures	2	2
(c) Operative endoscopy		
C. (a) Radical excision or dissection for malignancy.....	3	3

III. Technical skill required (Ts)

Assuming that the surgeon is qualified by training to perform the procedure; the evaluation should indicate that the degree of application of the surgeon's skill required is

minimum	1	0.0-1.5
average	2	1.6-2.5
advanced	3	2.6-3.5
maximum	4	3.6-4.5

IV. Aftercare (Ac)

Assuming a typical postoperative course, and adequate attention, the necessary aftercare period would

not exceed 24 hours	0	0.0-0.5
not exceed 1-3 days	1	0.6-1.5
not exceed 4-10 days	2	1.6-2.5
not exceed 11-30 days	3	2.6-3.5
not exceed 31-90 days	4	3.6-4.5
exceed 91 days	5	4.6-5.5

V. Duration of operation (Do)

Assuming the surgeon to be neither unusually rapid nor unduly slow, the average operating time would be

30 minutes or less	1	0.0-1.5
30 minutes to 1 hour	2	1.6-2.5
1 to 2 hours	3	2.6-3.5
over 2 hours	4	3.6-4.5

FORMULA:

$$Sf + Sp \times Ts + Ac + Do = \text{Professional Services Index}$$

The addition of the index values for the first two factors creates a figure proportionate to the relative magnitude of the operation to be performed; to properly reflect the most important consideration of "how much skill will be required to do the operation?" we multiply the figure by the index value for the technical skill. The subsequent successive additions of the index values for Aftercare and Duration of operation increase the total (to a lesser degree than did the multiplication by the Ts factor but adequately, nevertheless) in proportion to their importance in the overall problem.

In using *average selection* as the basis for evaluation it is necessary that the index values of certain factors in the formula be used as decimals rather than whole numbers. In the original studies using

majority selection the formula dealt with whole numbers, "average" technical skill for instance having an index value of 2. Since *average selection* will produce fractional indices it is necessary that the index value of "average" technical skill be made 1.6-2.5 rather than 2 in order to reflect the true value of an index such as 1.9 which must be considered closer to an index value of 2 rather than an index value of 1.

It is to be noted that the averages for 25 surgical procedures by the physicians of both States vary by only 0.1 index units. Despite the variations by either State regarding individual procedures which are shown above as "variations from averages," the mean individual variation from the combined average was plus or minus 0.5 index units.

COMPARISON OF PROFESSIONAL SERVICES INDICES, DEVELOPED INDEPENDENTLY ACCORDING TO THE FORMULA IN CONNECTICUT AND MONTANA USING AVERAGE EVALUATION

PROCEDURE	PROFESSIONAL SERVICES INDEX			VARIATIONS FROM ACTIVE	
	CONNECTICUT	MONTANA	AVERAGE	CONNECTICUT	MONTANA
Appendectomy.....	11.9	11.8	11.85	+ .05	— .05
Cholecystectomy.....	17.2	17.0	17.10	+ .10	— .10
Hysterectomy, abd. total.....	17.3	17.0	17.15	+ .15	— .15
Gastrectomy.....	22.0	21.6	21.80	+ .20	— .20
T & A, child.....	5.8	6.1	5.95	— .15	+ .15
D & C.....	4.0	3.9	3.95	+ .05	— .05
Hemorrhoidectomy, int. and ext.	9.7	10.3	10.00	— .30	+ .30
Nephrectomy.....	18.8	18.9	18.85	— .05	+ .05
Cystoscopy with ureteral cath.	4.4	4.8	4.60	— .20	+ .20
Mastectomy, simple.....	10.6	10.8	10.70	— .10	+ .10
radical.....	19.9	19.2	19.55	+ .35	— .35
Colon resection.....	21.5	21.0	21.25	+ .25	— .25
Fractured femur:					
closed reduction.....	10.7	9.8	10.25	+ .45	— .45
open reduction.....	16.5	15.3	15.90	+ .60	— .60
Fractured metatarsal:					
closed reduction.....	8.0	7.6	7.80	+ .20	— .20
Colles fracture:					
closed reduction.....	8.0	7.7	7.85	+ .15	— .15
Prostatectomy:					
Suprapubic.....	17.0	17.5	17.25	— .25	+ .25
Transurethral.....	17.2	18.1	17.65	— .45	+ .45
Submucous resection.....	12.0	12.6	12.30	— .30	+ .30
Ext. cataract lens.....	14.5	14.8	14.65	— .15	+ .15
Herniorrhaphy, ing.:					
Unilateral.....	11.0	10.7	10.85	+ .15	— .15
Bilateral.....	12.4	11.7	12.05	+ .35	— .35
Craniotomy, for tumor or abscess.....	25.2	25.1	25.15	+ .05	— .05
Varicose veins:					
Unilateral.....	11.1	10.0	10.55	+ .55	— .55
Bilateral.....	12.0	10.8	11.40	+ .60	— .60
Average index for the 25 procedures.....	13.5	13.4	13.45		
Mean individual variations from the combined average				+ .05	— .05

COMPARATIVE ANALYSIS OF THE CATEGORIES ASSIGNED THE 25 OPERATIVE PROCEDURES BY THE PHYSICIANS OF CONNECTICUT AND MONTANA ACCORDING TO THE THREE MAJOR FACTORS OF THE FORMULA

1. TECHNICAL SKILL REQUIRED

Assuming that the surgeon is qualified by training to perform the procedure, the evaluation should indicate that the degree of application of the surgeon's skill required is

MINIMUM (0-1.5)	CONN. MONT.	AVERAGE (1.6-2.5)	CONN. MONT.	ADVANCED (2.6-3.5)	CONN. MONT.	MAXIMUM (3.6-4.5)	CONN. MONT.			
		Appendectomy	2.0	2.0	Cholecystectomy	2.9	2.9	Gastrectomy	3.7	3.7
		T & A, child	1.7	2.0	Hysterectomy	2.9	2.9	Colon resection	3.6	3.6
		D & C	1.6	1.7	Nephrectomy	3.2	3.3	Craniotomy	3.6	3.7
		Hemorrhoidectomy	1.9	2.1	Mastectomy					
		*Cystoscopy	2.2	—	radical	3.3	3.3			
		Mastectomy, simple	2.1	2.2	*Cystoscopy	—	2.6			
		Fractured femur, closed	2.4	2.4	Fractured femur, open	3.1	3.1			
		Fractured metatarsal	1.8	2.0	Prostatectomy, suprapubic	2.8	3.0			
		Colles fracture	1.8	2.0	transurethral	3.0	3.3			
		Herniorrhaphy, ing. unilateral	2.1	2.1	Submucous resection	2.6	2.9			
		bilateral	2.2	2.1	Cataract lens	3.2	3.4			
		Varicose veins unilateral	2.1	2.0						
		bilateral	2.1	2.0						

In only one instance did the allocation by Connecticut and Montana of the Technical skill required for the individual procedures differ; cystoscopy was considered an "average" procedure by

Connecticut with an index value of 2.2 whereas the Montana evaluation considered it "advanced" with an index value of 2.6.

2. AFTERCARE

Assuming a typical postoperative course, and adequate attention, the necessary aftercare period would be

2-3 DAYS			4-10 DAYS			11-30 DAYS			31-90 DAYS		
INDEX VALUE			INDEX VALUE			INDEX VALUE			INDEX VALUE		
(0.6-1.5)		CONN. MONT.	(1.6-2.5)		CONN. MONT.	(2.6-3.5)		CONN. MONT.	(3.6-4.5)		CONN. MONT.
T & A, child	1.3	1.0	Appendectomy	2.2	2.0	*Cholecystectomy	2.8		Fractured femur,		
D & C	1.3	1.1	*Cholecystectomy		2.5	*Hysterectomy	2.8		*closed reduction	4.1	
Cystoscopy	0.8	0.7	*Hysterectomy		2.4	Gastrectomy	3.5	2.9	*open reduction	4.2	
			Hemorrhoidectomy	2.3	2.1	Nephrectomy	3.0	2.6	*Craniotomy	3.6	
			Mastectomy			Mastectomy					
			simple	2.2	2.0	radical	3.2	2.6			
			Submucous			Colon resection	3.5	2.8			
			resection	2.2	1.7	*Colles fracture	3.2				
			Herniorrhaphy, ing.			Prostatectomy,					
			*unilateral		2.2	suprapubic	3.2	2.7			
			*bilateral		2.3	Prostatectomy,					
			Varicose veins			*transurethral	2.9				
			unilateral	2.5	1.9	Ext. of Cataract					
			bilateral	2.5	1.9	lens	2.9	2.5			
			Prostatectomy			Herniorrhaphy,					
			*transurethral		2.4	*unilateral	2.6				
			*Fractured			*bilateral	2.7				
			metatarsal	2.2	2.2	*Craniotomy		2.9			
			*Colles fracture	2.3	2.3	*Fractured					
						metatarsal	3.1				
						Fractured femur,					
						*closed reduction		2.9			
						*open reduction		2.9			

The allocation of aftercare showed the greatest variation of any of the three factors. Montana considered a 4-10 day aftercare period adequate for cholecystectomy, hysterectomy, unilateral or bilateral herniorrhaphy, transurethral prostatectomy, fractured metatarsal, and Colles fracture; Connecticut indicated that in each of these procedures an 11-

30 aftercare period was necessary. In addition, fractures of the femur both open and closed and craniotomy were felt to require 31-90 days aftercare by Connecticut and 11-30 days aftercare by Montana.

There were no differences in the allocation of duration of operation.

3. DURATION OF OPERATION

Assuming the surgeon to be neither unusually rapid nor unduly slow, the average operating time would be

30 MINUTES OR LESS		30 MINUTES-1 HOUR		1-2 HOURS		OVER 2 HOURS	
INDEX VALUE		INDEX VALUE		INDEX VALUE		INDEX VALUE	
(0.0-1.5)	CONN. MONT.	(1.6-2.5)	CONN. MONT.	(2.6-3.5)	CONN. MONT.	(3.6-4.5)	CONN. MONT.
T & A, child	1.1 1.1	Appendectomy	1.7 1.8	Cholecystectomy	2.8 2.9	Gastrectomy	3.7 3.9
D & C	1.1 1.1	Hemorrhoidectomy		Hysterectomy,		Colon	
Cystoscopy with		int. and ext.	1.7 1.9	abd. total	2.9 3.0	resection	3.6 3.8
ureteral cath.	1.4 1.5	Mastectomy, simple	2.1 2.2	Nephrectomy	3.0 3.1	Craniotomy,	
Fractured		Fractured femur:		Mastectomy, radical	3.5 3.4	for tumor	
metatarsal:		closed reduction	1.8 2.1	Fractured femur:		or abscess	3.6 3.7
closed reduction	1.3 1.4	Prostatectomy:		open reduction	3.0 3.1		
Colles fracture:		transurethral	2.3 2.5	Herniorrhaphy, ing.:			
closed reduction	1.2 1.4	Submucous resection	2.0 2.2	bilateral	3.1 3.1		
		Ext. cataract lens	2.0 2.1	Varicose veins:			
		Herniorrhaphy, ing.:		bilateral	3.2 2.9		
		unilateral	2.1 2.2	Prostatectomy:			
		Varicose veins:		suprapubic	2.6 2.8		
		unilateral	2.3 2.1				

ANALYSIS OF THE VALIDITY OF THE FACTORS IN THE FORMULA BASED ON THE COMBINED CONNECTICUT-MONTANA EVALUATIONS

- FACTORS:
- I. Surgical fields (Sf).
 - II. Surgical problems (Sp).

The above factors which are not discretionary in the use of the formula were not considered as variables and have been applied at the index values indicated in the discussion of the formula on page 760.

III. Technical skill required (Ts).

The evaluation of technical skill must be considered the most important factor in the formula. In the construction of the formula the sum of the evaluations of the two previous factors, "surgical fields" and "surgical problems" is multiplied by the evaluation of "technical skill." This is intended to produce a figure proportionate to the relative magnitude of these three factors which are the most important of the five which make up the formula. It is significant in the comparative studies described herein that of the three discretionary factors of the formula ("technical skill required," "aftercare," and

"duration of operation") closest agreement between the separate evaluations of both States is to be found in the evaluation of "technical skill required." In six of the twenty-five surgical procedure evaluations by the two States the variation was 0.2 index units; in seven the variation was 0.1 units and in ten procedures the index values were equal; there were three variations of 0.3 and one of 0.4.

The average variation of the "technical skill" evaluation of both Connecticut and Montana was 0.104 index units. This figure is identical with the variation noted in the application of the whole formula to the evaluations of both States.

IV. Aftercare (Ac).

The intrinsic nature of aftercare makes it reasonable to expect that it would show the widest variation in evaluations. It is interesting to note that in each of the twenty-five procedure evaluations Connecticut's evaluations were higher (representing longer periods of aftercare) than Montana by 0.1 to 1.3 units. In considering this finding it must be recalled that the evaluations of Connecticut were performed two years prior to those of Montana and it is probable that the changing pattern of medical practice which has measurably shortened the aftercare period of surgery is reflected in these figures. Another consideration is whether the hospitalization

and professional staff policies which would affect aftercare periods in the two States are significantly different.

The average variation of the combined evaluations of the aftercare factor of the two States was 0.524.

V. Duration of operation (Do).

We may expect a reasonable variation in each individual evaluation of duration of operation since the evaluating physician would be prone to reflect his personal characteristic of being either a slow, average, or rapid worker. Nevertheless the combined evaluations show a variation of 0.3 for two procedures; a variation of 0.2 for eight procedures and a variation of 0.1 for twelve procedures; the evaluations of three procedures were in agreement.

The average variation of the combined evaluations of the duration of operation factor by the two States was .888.

The degrees of agreement and variation of the separate evaluations by the two States gives substantial support to the validity of the mechanism by which these factors are used in the formula. The most important of the three, technical skill required, (which importance is reflected in the construction of the formula) demonstrates excellent agreement. The evaluations of the less important factors in the formula of aftercare and duration of operation (whose importance is also properly reflected in the formula) exhibit a wider variation than was true in the technical skill evaluations. These are, nevertheless, within reasonable limits for a statistical sampling of the size used in these studies and seem to have a valid place in the formula. It is probable that redefinition of aftercare to better delineate the evaluation categories would materially reduce the degree of variation.

CONCLUSIONS

1. The formula is a practical means to produce an objective professional services index.
2. It seems indicated that in view of the recommendation in the recent report of the Truman Committee to the Board of Trustees of the American Medical Association, the formula should have serious consideration for use in the development of a professional services index for the medical profession.

Hemagglutination Test in Arthritis

The May issue of the CONNECTICUT STATE MEDICAL JOURNAL included a paper on a modification of the hemagglutination test in rheumatoid arthritis (Boisvert, Hilburg and de Forest). The method has been shown to be of considerable aid in the diagnosis of rheumatoid arthritis.

Physicians may use this diagnostic test in their practice by sending one milliliter or more of blood serum in a sterile container to the Streptococcus Laboratory, Grace-New Haven Hospital, 789 Howard Avenue, New Haven. The charge is \$5.

Teaching of Tropical Medicine Disappearing

Because the Louisiana State University has found through a recent survey of medical schools that the amount of time allotted to parasitology has decreased slightly since World War II and that tropical medicine as an entity in teaching has almost disappeared, it has accepted a grant of \$80,000 from the China Medical Board of New York to support for two years a program of fellowships that will enable teachers of tropical medicine and parasitology in this country to obtain practical experience in these subjects in the tropics.

During the early part of the program fellows will receive training at the San Juan de Dios Hospital, San José, Costa Rica and at the School of Medicine, University of Puerto Rico, San Juan. There will be a brief period of orientation at the School of Medicine, Louisiana State University, before proceeding to the tropics. Four fellowship periods are planned for each year with one month intervals between periods, the first fellowship period occurred in July and August, 1955.

William W. Frye, dean of the School of Medicine, and Henry E. Meleney, research professor of medicine, are administering the program and Dr. Meleney is supplying information to all interested.

NEWS FROM WASHINGTON

Congress Closes First Session With Many Health Bills Pending

The 84th Congress wound up its first session August 2 after a last day compromise on a grants bill to aid States in paying for Salk vaccine programs through next February 15. Three days previously Senate and House finally agreed on \$30 million for financing of inoculations, just half what the Senate originally had voted.

Adjournment found two medically important bills at the half way mark in Congress: the Hill-Bridges \$90 million grants bill for construction of research facilities (passed the Senate and pending in House Interstate Committee) and the Democratic sponsored national compulsory disability insurance plan (passed the House and pending in Senate Finance Committee). Still before committees but with hearings completed are: Jenkins-Keogh tax deferment bills and federal aid to medical education.

Other bills facing Congress on its return in January: aid to nursing education, dependent medical care, contributory health insurance for federal workers, mortgage guarantees for health facility construction, reinsurance of voluntary health plans, military medical scholarships and practical nurse training. Health bills, President Eisenhower reminded a press conference, should be handled as soon as Congress comes back.

New Bills Introduced

Imminence of adjournment did not discourage introduction of more health bills. One of them is HR7608, authorizing Federal mortgage loan insurance for construction of nursing homes. Filed by Rep. J. Percy Priest (D-Tennessee), its language is substantially that of Title 2 of Administration's omnibus national health bill (S886), except that it provides solely for nursing homes, both of the proprietary and nonprofit type.

HR7621, sponsored by Rep. Albert Rains (D-Alabama), provides for Federal food subsidies to hospitals erected with Hill-Burton assistance. HR7602, by Rep. Eugene Keogh (D-New York) grants tax deductibility for gifts made to nonprofit voluntary health insurance plans. Rep. Harris Ells-

worth (R-Oregon) introduced HR7425, making nonprofit air ambulance enterprises eligible to receive Federal surplus property.

Rep. Irwin D. Davidson (D-New York) introduced a Hill-Burton amendment bill (HR7838) authorizing \$20 million in Federal grants to promote construction of psychiatric hospitals and clinics and \$5 million for facilities devoted to treatment and rehabilitation of narcotic addicts. He also filed a scholarship bill (HR7839) whose main purpose is to increase supply of physicians and public health workers.

Among other new bills: S2700 (Flanders, Ives, Lehman), extending tax deductibility to gifts made to nonprofit voluntary health insurance plans requested by Group Health Insurance, Inc., of New York); S2751 (Langer), permitting dentists and lawyers to participate in old age and survivors insurance on voluntary basis.

President Eisenhower signed HJ Res. 256, calling for 3 year survey of problems of mental health and illness. Supplemental appropriations bill, as finally enacted, contains \$250,000 for its launching.

Same appropriations bill carries \$350,000 to plan a new home for Armed Forces Medical Library (sum was stricken by Senate but restored in conference); \$1,190,000 to implement new air pollution control law; \$30 million in State grants for purchase of vaccine; \$4.5 million for grants to States for planning and administration of vaccine programs; \$600,000 to erect monkey quarters at National Institutes of Health, and \$300,000 to Food & Drug Administration to strengthen inspection branch.

HEW Appropriations Bill Passed, Sent to President

The appropriations bill for the Department of Health, Education, and Welfare has been passed by Senate and House, following agreement in conference. In a few cases the conference committee accepted the higher Senate figures, and in many more reached a compromise between Senate proposals and lower House figures. In the final agreement, the regular Hill-Burton program to aid in hospital construction received \$90 million, the high-

est figure in six years. The House had voted \$75 million and the Senate \$104 million. Both chambers had voted \$21 million for the new HB program of aid to clinics, centers and special-type hospitals, so this was not an issue in the conference committee.

Other Public Health Service items include: Aid to States, general, \$13.66 million as proposed by Senate instead of \$12 million proposed by House; tuberculosis control, the House figure of \$4.5 million instead of the Senate's \$5 million; communicable disease control \$5.25 million as proposed by the Senate instead of the \$4.4 proposed by the House; cancer research \$24.828 million instead of the \$22.238 million proposed by House and \$26.4 million by Senate; mental health \$17.751 million, the House figure, instead of the Senate figure of \$21.850 million; heart research \$18.778 million, instead of \$17.278 million proposed by House and \$23.80 million by Senate; arthritis and metabolic disease \$10.74 million instead of \$8.740 million proposed by House and \$12.725 million by Senate; microbiology \$7.580 million, the Senate figure, instead of the House figure of \$6.645 million; neurology and blindness \$9.861 million, instead of \$8.861 million as proposed by the House and \$11.850 by Senate; Indian health \$5 million, the Senate figure, instead of House proposal of \$4.75 million; operating expense for National Institutes of Health \$5.899 million, the Senate figure, instead of \$5.339 million, the House figure.

The conference report states that Congress expects \$850,000 will be used for work on poliomyelitis, and this amount was added to the House recommendation for communicable diseases, but this provision is not written into the bill to avoid accounting complications. Both chambers passed the bill July 20, the day after the conferees finished their work.

Mrs. Hobby Makes Final Report to President on Polio Vaccine

In one of her final reports to the President before resigning as Secretary of Health, Education, and Welfare, Mrs. Hobby on July 27 announced that details for interstate distribution of the Salk poliomyelitis vaccine had been worked out with State governors, medical groups and the industry. This is the program that will go into operation on completion of the current National Foundation for Infantile Paralysis program. Other points cited for the President: (1) since the first of July, PHS has released almost 2.5 million cc.'s of vaccine and

during August the rate of supply of new vaccine should begin to increase considerably, (2) the governor of each State, territory and possession has appointed an official to serve as liaison with the National Advisory Committee on Poliomyelitis Vaccine and to develop an intra-state distribution plan, and (3) the American Medical Association has asked physicians to vaccinate only children within the 5-9 age group until further notice and to keep records of each vaccination, including name of manufacturer and lot number of the vaccine.

Voluntary Allocation of Salk Vaccine Begun in States

The Department of Health, Education, and Welfare's voluntary allocation plan for Salk poliomyelitis vaccine was placed in operation August 1. Simultaneously, HEW announced allocation of 846,000 cc.'s of vaccine to the States for distribution to local health agencies and private physicians. Action came after the National Foundation for Infantile Paralysis reported that it had enough vaccine on hand for its needs for the rest of the summer. The voluntary program was worked out by the National Advisory Committee on Poliomyelitis Vaccine, the Public Health Service, the Governors' Polio Advisory Committee, Association of State and Territorial Health Officers, American Medical Association and other groups. Some of the key points in the program: (1) each new batch of vaccine will be allocated among the States as it becomes available, (2) States will determine what proportion of their share is to go to public agencies and what amount manufacturers will distribute through normal drug channels for use by private physicians, (3) State allocations to be based on each State's proportion of children in the 5 to 9 year priority group, exclusive of children who have been inoculated this year under the polio foundation program.

HEW said it has asked all States to notify the department of amounts of vaccine needed for public agencies and druggists, and that as soon as this information is received in Washington it will be transmitted to manufacturers, who will make direct shipments to the States.

Latest Data Presented on Doctor Draft Pool

Selective Service figures on special registrants under doctor draft law, as of June 30, disclose a

sharp rise in number of Priority III physicians (non-veterans). Total on that date was 40,596, compared with 38,322 for May 31. June graduations were partly responsible for increase, though there was no corresponding rise for dentists. Those in Priority III on June 30 totaled 15,797, which was only 392 above the May figure. Figures are still unavailable on number of special registrants affected by new draft law's provision exempting those over age 35 whose applications for military commissions were rejected on grounds of physical disability.

Dr. Keefer Resigns

Chester S. Keefer has resigned as Special Assistant for health and medical affairs to the Secretary of Health, Education and Welfare. Dr. Keefer left his post to take up his new duties as director of medical affairs at Boston University and coordinator of professional activities at Boston University and Massachusetts Memorial Hospital.

PHS Officers Assigned to All Salk Vaccine Plants

From now on the Public Health Service will have one of its officers assigned to each of the six plants producing Salk vaccine. They will assist in production and testing procedures, help to coordinate the industry's research, and facilitate a more rapid exchange of information between the pharmaceutical industry and the federal government.

At the same time, PHS initiated a research plan, described as an expedient, to improve production and testing of poliomyelitis vaccine. Universities and other nonfederal institutions will cooperate. Among subjects to be investigated are the inclusion of other strains of virus in vaccine, improved potency tests, the improvement of monkey safety tests, the development of concentration methods of use in both testing and production processes, and studies on standardization of tissue culture susceptibility to the polio virus.

Program Prepared to Make Military Medical Career Attractive

A special Defense Department task force has drawn up a five-point program designed to make military medicine more attractive as a career. Legislation required to implement parts of the report will be introduced later, after the changes have been

approved by the Budget Bureau and cleared by all affected services and departments. The task force points out that in 1950 more than half the military physicians were members of the regular corps, but that now less than one-third of all officers and less than one-sixth of those in the three lowest grades are career doctors. In one 21 month period, the task force notes, 766 regular medical officers resigned, but only 364 signed up for a regular career, and most of these to take advantage of residencies or other educational incentives.

The task force makes these recommendations: 1. Increase voluntary procurement through educational assistance in exchange for active service. 2. Improve financial appeal through higher starting rank plus longevity credit and constructive service for medical education years. 3. Extend service contracts based on a bonus plan to keep men in service after completion of obligation under the regular draft. 4. Guarantee optional retirement after 20 years' service. 5. Improve military and professional environment so as to increase professional motivation and prestige.

Recommendations of the task force were reviewed at a Pentagon meeting attended by representatives of the American Medical Association and others.

Selective Service Urges Deferments for Medical Science Teachers

Reserving its position following a formal protest from the American Medical Association, the National Selective Service System is requesting local draft boards to give "particularly careful consideration" to deferment for teachers "in any of the fields of physical . . . science, . . . medicine, or dentistry."

At the June convention the House of Delegates adopted a resolution noting that the practice in medical schools is to use as instructors and assistants students who interrupt their medical education for this purpose. But, the resolution states, "this source of assistants and future teachers has been eliminated by the policy of Selective Service of drafting these students as soon as they have lost their medical status." The effect, resolution states, is that "medical schools of the country have been hampered in their effort to provide the best education in the preclinical departments," and that the training of medical students is "being seriously jeopardized."

Copies of the resolution were sent to the President and to members of the House and Senate. Selective Service added "biological sciences, medicine and dentistry" to the list of currently critical occupations, for which draft deferment is advised.

Two More Self-Treatment Products Take FTC Cure

Federal Trade Commission has approved stipulations with two companies which will curb advertising claims for "Leg-Eze Home Application Kit" and "Poundex." Los Angeles firm which markets former agrees not to represent it as a cure for phlebitis or as a preventive or cure for varicose veins. Kit is a combination of drug preparations and devices. In "Poundex" case, its New York manufacturer consents to withhold representations that it will increase body weight, unless expressly limited to cases of poor appetite or bad eating habits.

In a new complaint issued last week, FTC charges a St. Paul company with making false claims for its products, called "Yo-Zyme" and "Vinol-Tonic." Former is advertised as a treatment for hemorrhoids, migraine, gall bladder conditions, etc. FTC disputes veracity of these claims, also those advanced for tonic properties of sister product.

CONNECTICUT POSTGRADUATE SEMINAR IN PSYCHIATRY AND NEUROLOGY, INC.

The Ninth Connecticut Postgraduate Seminar in Psychiatry and Neurology will begin its courses of lectures on September 26, 1955 and will continue through May 7, 1956.

From September 26 through December 5, 1955 sessions in clinical neurology, neuroradiology, electroencephalography, neuroanatomy, neurophysiology, and neuropathology will be held on Mondays and Wednesdays from 3:00 to 9:00 P. M. at Yale University School of Medicine, New Haven.

From January 9 through March 5, 1956 (Mondays) from 3:00 to 10:00 P. M. sessions in general psychiatry (psychopathology, clinical psychology, psychiatric syndromes, therapy, psychosomatic medicine, geriatric psychiatry and psychiatry and law) will be held at the Connecticut State Hospital, Middletown.

March 12 through April 16 (Mondays) from 6:30 to 9:45 P. M. a course in child psychiatry will be given, and April 23 through May 7, 1956 (Mondays) from 4:30 to 10:00 P. M. there will be a course in pediatric neurology, both at Yale University School of Medicine, New Haven.

There are no fees for the above courses.

Copies of the program may be obtained from the Office of the assistant dean for Postgraduate Medical Education,

Yale University School of Medicine, 333 Cedar Street, New Haven, Connecticut.

Scranton Memorial Library Additions

The E. C. Scranton Memorial Library at Clinton, Connecticut has added to its shelves three medical magazines, an art magazine, architectural monographs and a weekly news bulletin magazine.

Dr. Mila L. Rindge has presented subscriptions of the *Journal of American Medical Association*, the *CONNECTICUT STATE MEDICAL JOURNAL*, and the *American Journal of Public Health*.

A gift subscription to the *American Artist* has been received from Mrs. Marvin Stevens.

James Jackson has presented a number of pamphlets on old American architecture.

Admiral Reginald Belknap has donated *The Weekly Bulletin*, a digest of editorial opinion as expressed in small town newspapers in the United States and Canada.

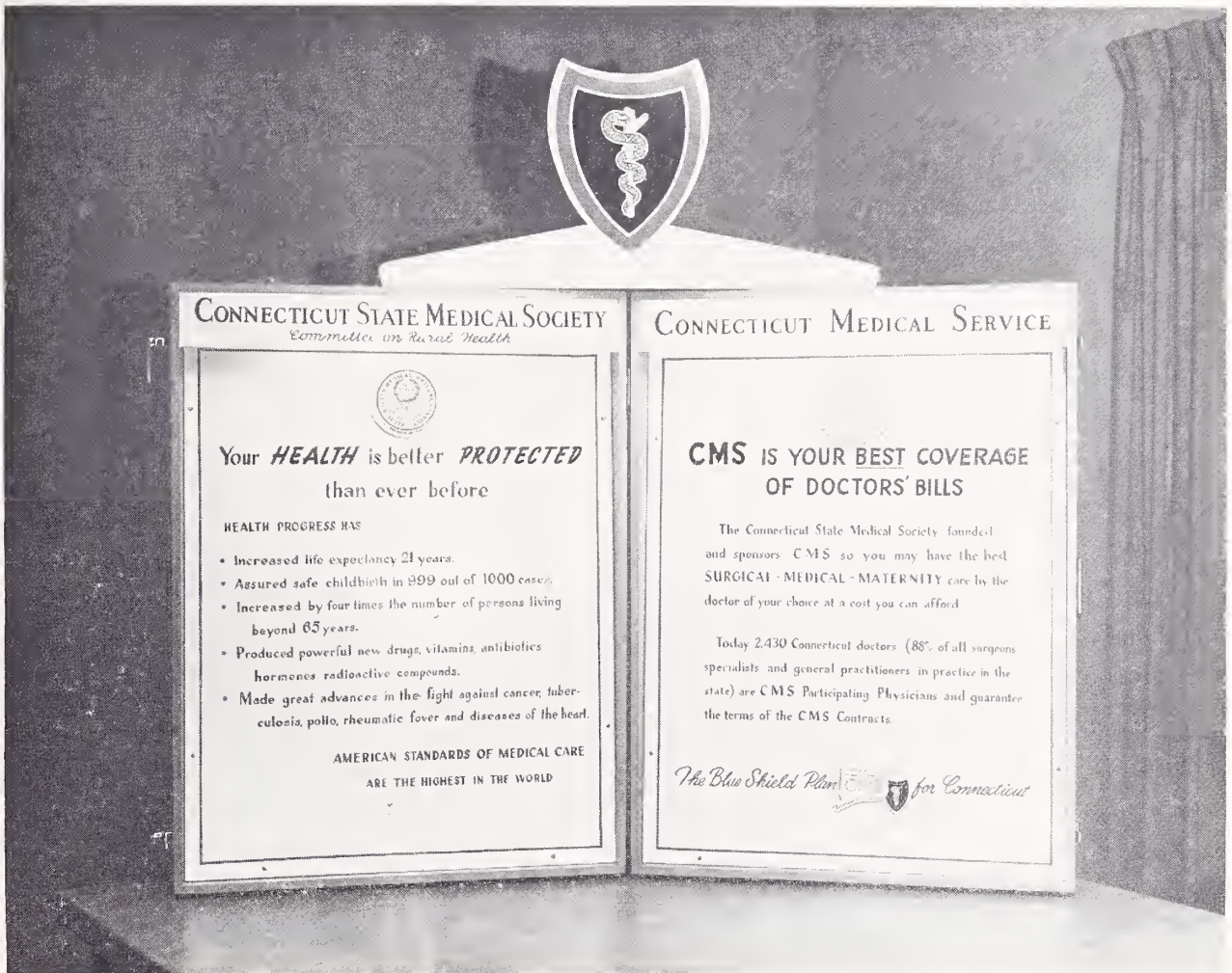
Mass Medicine Appraised

"I also hope that we taxpayers will picture the type of administration which the sick person could expect to encounter under government made medicine. The slow pace, the inflexibility, the irritations and the mass mediocrity which civil service and its procedures present in many places, are not very palatable to the citizen beyond the Potomac.

"The spectre of thousands of little men and women swarming over the country, making jobs out of compulsory medicine, making the costs exorbitant, and making people's lives miserable with their rule books and myopic view of humanity seems not too difficult to conjure. Before we bring this picture upon ourselves, let us extend the thousands of voluntary hospital and medical plans, let us tailor them to the needs of each individual group, with costs related to and controlled by use, and with individuals budgeting and taking care of their own needs, with the right to say who shall treat them.

"As for myself, this body which I inherited could stand improvement, but it is the one in which I must live, and as long as it is precious to me, I want some control over whoever tries to keep it in repair."—From "A Businessman's Appraisal of Mass Medicine," by Robert A. Hornby, *American Economic Security*, June, 1949.

HEALTH PROTECTION



Several exhibits of this type are being displayed at Connecticut fairs to help tell the story of health protection.

Local committees of the Woman's Auxiliary are managing the project, which is sponsored by the Society's Committee on Rural Health and Connecticut Medical Service.

PUBLIC RELATIONS

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Newspaper Survey Seeks Best Way to Summon Medical Aid

The *Northern Connecticut News*, a weekly community newspaper, recently conducted a survey among physicians in the Thompsonville area.

The survey sought to determine the most practical ways in which to summon medical aid in both routine and emergency cases. The results of the survey were published in the July 21 issue of the newspaper.

Results of the poll indicated that routine calls should be made between 7:00 and 8:00 A. M. to assure that a physician could make a home visit the same day. This recommendation was made because physicians in the community must visit their patients in hospitals either in Hartford or Springfield, and for that reason are not always available for house calls at hours later in the day.

In handling emergency calls the following recommendations were indicated by the survey:

1. Call your family physician first.
2. If your own doctor is not available, an associate physician should be covering his calls and can be reached by the telephone operator.
3. Give the name and number of the street and as much information about the locality as possible so that your physician may reach the scene quickly.
4. Answer as fully as possible the questions the physician may ask you on the telephone. This will enable him to advise what to do for the patient while waiting for medical assistance.

Medical Association Exhibit Scheduled for Danbury Fair

A health education exhibit will be operated at the Danbury Fair, October 1-9, by the physicians of the Fairfield County Medical Association.

The twelve foot exhibit, entitled "You Can Reduce," will be furnished by the Bureau of Exhibits

of the American Medical Association. Leaflets containing information about weight control will be distributed as a feature of the project.

The exhibit will mark the second consecutive year that the Association has participated in the Danbury Fair. The exhibit last year concerned organs of the human body and proved highly successful in attracting thousands of fair-goers. The exhibit this year will occupy approximately twice the space devoted to the exhibit last year.

A panel of physicians to supervise the project is now being organized and they will be assisted by members of the Woman's Auxiliary.

Hartford and Fairfield Appoint AMEF Committees

Committees to represent the American Medical Education Foundation were recently appointed by Medical Associations in Hartford and Fairfield Counties.

Charles E. Jacobson, Jr., Manchester, representative of the Hartford County Medical Association on the AMEF Committee of the State Medical Society, has been named chairman of the Hartford County committee. Members are: Henry Pollock, Bristol; Andrew Canzonetti, New Britain; Walter P. Kosar, Hartford; Joseph Gordon, ex officio.

Members appointed to a similar committee in Fairfield County are: Newell W. Giles, Stamford; John W. Jovell, Danbury; Robert A. Northrop, Norwalk; Milton M. Lieberthal, Bridgeport, representative on the State AMEF committee. The chairman of the committee will be named soon.

Functions of the committees will be to implement the fund raising program for the medical schools which has been conducted for the past several years by the State AMEF Committee.

At the first meeting of the Hartford County Committee, on July 14, a plan was adopted which will encompass a mailing to all members of the Associa-

tion and activation of a telephone committee to follow up the letter campaign. It is proposed to place an advertisement in the monthly publication of the Association and to furnish information concerning AMEF activities for readings at medical staff meetings and publication in hospital news letters.

National PR Institute Sponsored by AMA

More than two hundred and fifty chairmen of Public Relations Committees and county and State medical association staff members attended the Public Relations Institute sponsored by the American Medical Association in Chicago, August 31-September 1.

The program comprised talks and general discussions on a variety of Public Relations activities and a forecast of new techniques being incorporated in community service programs. Various activities of medical associations throughout the country were portrayed in exhibits which featured the two day session. Also featured were showings of sound films available for use on television programs and for bookings at schools, clubs, industrial plants, and organizational meetings.

For Your Patients Only

An attractive new leaflet earmarked "for patients only" will be distributed in September to members of the AMA. Entitled "To All My Patients," this 12 page pamphlet (for physicians to distribute to their patients) explains the roles of various persons on the medical team in providing good medical care. In addition, the booklet briefly discusses medical and hospital fees and health insurance. Designed primarily to promote better doctor-patient relationships, the booklet also provides space for the physician's name, address and office hours. They will be available on request through the office of the State Medical Society.

New TV Shows This Fall

The fall schedule for two network medical television programs being produced with the cooperation of the American Medical Association will get started in September. First, Ciba's new "Medical Horizons" show, a half-hour weekly TV series will be premiered over the ABC-TV network Monday, September 12, from 8:30 to 9:00 P. M., C. D. T. This documentary series will promote the American way of medical life by presenting specific accomplish-

ments in the field of medicine as exemplified by the teamwork of modern medical research, education and practice. Featured will be live telecasts from medical institutions and research centers throughout the country.

The first of six shows in the 1955-56 series of "March of Medicine" programs presented by Smith, Kline and French Laboratories, will be telecast Tuesday, September 20 over the NBC-TV network. This will replace Armstrong Cork Company's "Circle Theater," at 9:30 P. M., E. D. T.

Medical Films Viewed by More Than 2,500 Persons

A recent survey discloses that two medical association sound films, "Your Doctor" and "Operation Herbert" were viewed by more than 2,500 persons in Connecticut during the first six months of this year.

The largest total audience comprised 1815 high school students who viewed the film "Your Doctor." This film was also shown to approximately 100 members of clubs and other organizations.

A total of 2,778 persons viewed the films, with "Operation Herbert" being shown to a total audience of 863 persons in employee organizations, clubs and social groups.

Health Protection

Several exhibits of this type are being displayed at Connecticut fairs to help tell the story of health protection.

Local committees of the Woman's Auxiliary are managing the project, which is sponsored by the Society's Committee on Rural Health and Connecticut Medical Service.

New Orders for Controls on Welfare Expenditures

Christy Hanas, Commissioner, State Department of Welfare, has announced the establishment of rigid controls on medical care expenditure for welfare cases. With medical expenses costing tax payers approximately $4\frac{1}{2}$ million dollars annually, the department is greatly concerned. Although only a portion of the State's expense involves care in hospitals for the acutely ill, hospital bills are to receive the same careful scrutiny as those submitted by

doctors, dentists, convalescent hospital and druggists.

Effective immediately, the department will: (1) insist on strict compliance with all regulations issued by the Hospital Cost Commission, (2) pay for beneficiaries in short term general hospitals only during the period of definitive treatment, (3) require a discharge summary in duplicate to be prepared on each beneficiary for the guidance of the attending physician and the district welfare office.

It was stated that a closer follow-up of welfare cases in voluntary hospitals will soon be inaugurated by district offices: "Soon after receiving the usual notification that a State Welfare beneficiary has been admitted to a State-aided hospital, a worker from the district office will visit the hospital, supply any pertinent medical and social data available from the beneficiary's files, and assist in planning for placement and future care following hospital discharge." It was reported that this control of expenditures for hospital care will be achieved by "a trial of strict enforcement of the rules and regulations now on the books but every effort will be made to avoid setting arbitrary limits to services and expenditures."

The State Welfare Department cannot pay for:

1. High priced drugs, when therapeutically equivalent preparations are available at lower prices.
2. Trade-name preparations, when therapeutic equivalents are available under USP or standard terminology at lower prices.
3. Specially packaged drugs, when standard packages are available at lower prices.
4. Injectable preparations, when oral equivalents are available.
5. Sera, vaccines and other immunizing products, since these are provided free of charge by the State Department of Health, through local health directors, to any physician for the use of the State's indigent, including Welfare beneficiaries.
6. Vitamins, except when prescribed for the treatment of demonstrable vitamin deficiencies, in accordance with the recommendations of the Council on Pharmacy of the American Medical Association. "Maintenance vitamins" will not be paid for. Injectable vitamins will be paid for only when need for same is substantiated by clinical data submitted by the prescribing physician to the district office, attention of the Medical Director.

7. Drugs prescribed in the treatment of obesity.

8. Antibiotics, when prescribed for the common cold, influenza, or other diseases generally known to be unaffected by them.

9. Broad spectrum antibiotics, except when in the judgment of the prescribing physician penicillin and/or other lower priced antibiotics and chemotherapeutic agents could not reasonably be employed. (The AMA Council on Pharmacy states that the majority of cases requiring antibiotics can best be treated with penicillin.)

10. Drugs and medicines prescribed and administered over a long period without occasional interruption to determine their effectiveness and the advisability of their further administration.

11. Narcotics, barbiturates or other habit forming drugs in amounts greater than the minimum clinical need of the beneficiary.

The substance of these regulations has been approved by the State Medical Society, hence any conflict with prescriptions should be resolved by conference between the physician and the pharmacist.

Taxes at AMA

AMA Comptroller Edward A. Hoffman cited some tax figures the other day which should interest the 153,000 physicians who make up the American Medical Association.

During the first six months of 1955, the AMA, acting as Uncle Sam's tax collector, withheld from employees' paychecks \$309,721 in federal income (withholding) taxes.

During the first six months of 1955, the AMA, again serving as collector, withheld \$41,371 from employees for social security taxes and, in addition, the AMA had to match this amount, sending a check to the U. S. Treasury at the end of June for \$82,742.

For workmen's compensation, which is a form of compulsory insurance in case of injury of an employee, the AMA paid a premium of \$3,776 covering the first six months of the year.

The State unemployment tax, paid by the AMA and covering a six months' period, amounted to \$5,441.

The federal unemployment tax, also paid by the AMA and covering a six months' period, was \$4,500.

FROM OUR EXCHANGES

Sabin of the University of Cincinnati in a paper delivered at the recent meeting of the Association of American Physicians (*Science* 121:3152, p. 758) describes encouraging progress in his work with 30 prisoner volunteers who received live polio virus last January. All 30 participants in the experiment, inmates of the Chillicothe, Ohio, federal reformatory, produced resistance to the disease in the form of antibodies. In addition, none of the volunteers became ill from the infection they developed; in fact, infection could be determined only by laboratory tests. The men received varying amounts of the virus culture in a teaspoonful of milk. It was found that 0.001 ml. of the fluid was enough to produce an immunizing infection.

The work, aided by a grant from the National Foundation for Infantile Paralysis, is still in progress. After successful experiments in which the viruses were changed from highly virulent or paralyzing varieties to nonvirulent or harmless varieties, the strains were considered safe for testing on human beings.

* * * *

Graham and Graham at the Massachusetts General Hospital, Boston, (*Bull. Amer. Cancer Soc.* 5:2, pp. 56-62) have found that some patients with cancer of cervix show a characteristic change in the nonmalignant cells of the vaginal smear. This they term the sensitization response or S.R. Patients with a strong S.R. respond favorably to irradiation therapy. Other patients observed with smears during radiotherapy and having weak S.R.'s will not benefit from radiotherapy and will do better with surgery. The S.R. is not of the same prognostic value in patients treated surgically.

The Grahams also found that the effectiveness of radiotherapy is enhanced by paying attention to the general condition of the patient and by the administration of supplemental agents such as testosterone propionate or alphatocopherol.

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Hughes reporting in the *New York State Journal of Medicine* (55:12, pp. 1746-1754) on "The Fetal Salvage Program in Syracuse, New York" comments on trends discovered in the operation of a Precon-

ceptional Diagnostic and Therapeutic Clinic. The outstanding abnormal finding in the 91 couples analyzed centers about nutrition. This appeared to be reflected in the functioning of the endometrium. Infant mortalities have been found to be associated with placental pathology in about half the cases.

* * * *

Dickel *et al.*, (*Canad. Med. Assoc. Jour.*, 72:1, pp. 1-6) state that with few exceptions the fundamental knowledge of the whole field of psychoneurosis has been little advanced during the first half of the present century. Psychoneurosis is today a controversial subject; and is the product of a variety of conditions.

The authors believe that in the whole area of psychoneurosis there is one distinct group that can be classed as a clinical entity which they name "the anxiety tension syndrome" or "the anxiety tension state."

The discussion is long and a little confusing. Perhaps the average reader will be left with the impression that the anxious patient is common today. They do not often come to the physician when their anxiety is at its highest but when the individual's fatigability, tiredness, inability to rest comfortably, blueness and discouragement have reached a point where he obviously needs help. These anxiety tension syndromes in the opinion of the authors can be recognized by the man in practice. Such patients can easily be instructed by the physician to handle with equanimity the things that bother them. It is the business of the psychiatrist to teach the average practitioner the techniques of handling these patients. The point is stressed that in general practice good and encouraging results can be obtained for these people with a minimum of time expended, with a minimum outlay of money, and with little or no time lost from work either for treatment or from future distress. The outlook for these patients is good if they are properly handled.

* * * *

Buckman calls attention in an editorial to the fact that "Critical Mastoiditis (is) on the Increase." He thinks that children were safer 30 years ago with early incision of the ear drum. "Secretory otitis thus

drained subsides early and involution is assured; when masked inadequately with penicillin it leaves the middle ear jeopardized and leads the way to deafness. A single dose of penicillin, parentally followed by oral administration, is not adequate treatment in the opinion of otologists who have seen the present day swing back to mastoiditis and its complications." (*Penn. Med. Jour.*, 58.)

* * * *

"Current Considerations of Tonsillectomy" contains a good discussion of the present status of this operation (McLaurin and Raggio, *Jour. Louisiana State Med. Soc.*, 107:3, pp. 91-98). The authors agree that there are disconcerting figures in favor of and against the operation but add that their own feeling is that the present tendency is not to advise tonsillectomy often enough. The surgical indications have not been altered by the introduction of the antibiotics. These drugs are useful in tiding a patient over an acute attack, but they have no effect on intrinsically diseased tonsils and they have no effect at all in some of the circumstances in which removal of the tonsils is justified.

The authors assert that it remains to be proven whether the operation influences the development of poliomyelitis, either immediately or remotely, but they agree that it is the part of wisdom to refrain from elective surgery during any kind of epidemic. They condemn the performance of the operation by untrained physicians and the tendency to regard it as minor surgery.

* * * *

Tice rather briefly describes his "Experience with a New Urographic Agent—Hypaque" (*Jour. Kansas Med. Soc.*, LVI:III, pp. 130-132). He used the new agent in 218 patients.

There were some side effects. Sixteen of the cases tested complained of nausea, which in most instances was slight. Five patients vomited and two showed a slight urticaria. Put in another way it can be said that 91.8 per cent of the patients were completely free of any side effects. There was no significant blood pressure drop, no respiratory distress and no vein cramps in any case in the series. In Tice's experience most films demonstrated clearly the renal pelvis, ureters and bladder. The author's best films were taken at four minutes.

The conclusion of Tice is that "it is our impression that the density, dependability, speed of concentration, and general lack of discomfort to the

patient when Hypaque is used cause this media to compare favorably with any available today."

* * * *

It is recognized that an important factor in the pathogenesis of hypertension is the role of the kidney. The mechanism by which hypertension is produced in renal disease remains obscure.

Imber and Cymer report a case in which malignant hypertension was caused by an extrinsic compression of the right renal artery and which was permanently relieved by removal of the right kidney (*New Eng. Med. Jour.*, 252:8, pp. 301-304). The authors consider that the value of abdominal aortography in identifying the vascular defect is again demonstrated. This case provides further evidence that a diminished blood flow in a major renal artery may cause hypertension and impairment of total renal function.

* * * *

"Gout—Now Amenable to Control" is an opinion that is expressed by Bartels (*Ann. Int. Med.*, 42:1, pp. 1-10). The use of colchicine for the relief of pain has long been associated with gout. Over the years many attempts have been made through restricted diets and the use of uricosuric agents to remedy the basic problem of gout, that of hyperuricemia. Those doctors specially interested in gout have been waiting patiently for the discovery of a substance that would accomplish for gout what insulin has done for diabetes. Bartels thinks that this era is at hand with the discovery of Benemid.

Benemid at this point presents many problems. They include such factors as dosage, the "rebound" phenomenon, combination of Benemid with diet measures, the question of which cases should be treated, undesirable side effects (4.8 per cent) and how long should the medication be continued. "Finally, further time will be required to prove whether tophi will be substantially decreased in size under Benemid treatment, and whether the bone damage of gout is reversible. Our studies are inconclusive on this point; tophi have stopped discharging and the visible tophi have decreased slightly in size, but objective bone deformity and retrogressive roentgenographic bone changes have not as yet been observed."

A careful reading of Bartels' article suggests that Benemid as an agent for the treatment of gout is well worth watching but that it is not ready yet for universal acceptance.

There are few hospital tragedies greater than the appearance of epidemic gastroenteritis in the nursery. McClure details his experience with such an epidemic (*Canad. Med. Assoc. Jour.*, 72:2, pp. 83-85). All exposed infants were discharged from the nursery before new admissions were allowed. Infants were breast fed and few complementary feedings were used. Rigid controls were enforced and can be briefly summarized as follows:

1. Rigid nursing techniques in all nurseries for the newborn.
2. Prompt isolation of the mother with diarrhea and the removal of her baby from the nursery.
3. Isolation of any infant in the nursery showing signs or symptoms of gastroenteritis such as listlessness, lack of appetite, diarrhea, vomiting or abnormal loss of weight.
4. Breast feeding whenever possible for all infants while in the hospital. Complementary feedings if the infant does not gain weight after the fourth day following delivery.
5. Adequate and early treatment of all infants with gastroenteritis to correct dehydration, including interstitial and intravenous medication.
6. The use of the broad spectrum antibiotics to which the pathogenic *E. coli* are susceptible.
7. The appointment by the medical staff of a physician to act as a consultant in pediatrics in the nursery and pediatric ward.

Ed.: This is a good resume of the subject. It can be added that it is doubtful if gastroenteritis should be treated on the children's ward except in those situations where the nursing techniques are rigidly enforced and where there are adequate provisions for isolation. Nurseries for the newborn infants on all occasions should be adequately supervised as to routine care and feeding techniques. Isolation should be enforced on suspicion of gastroenteritis.

It is probable that most hospitals should give more attention to the history of diarrhea in the mother and among the personnel having contact with the nursery. The attention to this matter should be continuous and not limited to the hot months of the year. Some of the worst nursery epidemics of diarrhea have occurred in the winter months. It is probable that all such epidemics can be traced to an adult or child who has recently had diarrhea—often in what appears to be a mild and innocent form.

* * * *

Splenic flexure syndrome is a symptom complex produced by an accumulation of gas trapped in the

splenic flexure of the colon. It is believed that this syndrome is a variant of spastic colon. Its chief interest lies in the fact that it is an entity that produces symptoms suggestive of coronary artery disease.

Spaeth (*N. Car. Med. Jour.*, 16:2, pp. 49-52) reports on 24 such cases that have been followed 30 months. In his experience recognition of the syndrome is important in the differential diagnosis of coronary disease. Emotional instability and stress are the main factors in initiating the attacks. Treatment consisted of psychologic readjustment and therapy directed toward relaxation of the intestinal tract.

* * * *

Turner and Fair in a study of 42 patients with toxemia of pregnancy at the University of Tennessee in Memphis (*Obst. & Gyn.*, 5:6, June 1955, pp. 804-810) conclude that because all patients benefited clinically from increased fluid intake and because no decrease in body sodium content could be demonstrated it is most unlikely that the sodium ion plays as prominent a role in the development of toxemia as previously thought. They believe that in addition to angiospasm the primary disturbance in toxemia is water retention which apparently is not dependent on abnormal sodium ion concentration.

* * * *

Nickerson presents evidence to indicate that excessive vasoconstriction is an important factor in the genesis of shock (*Jour. Mich. State Med. Soc.*, 54:1, pp. 45-49). Hypotension associated with vasodilatation is usually well tolerated for a long time. The contrary situation occurs in hypotension associated with vasoconstriction which ends in irreversible shock within a few hours.

The procedures of choice in shock that follow hemorrhage or trauma are those that increase the circulating blood volume or reduce vasoconstriction. The preoccupation with hypotension, an obvious and readily measured sign of shock, has led to the frequent use of vasoconstrictors in therapy. These agents are often effective in raising the blood pressure, but if the role of vasoconstriction in the evolution of shock is remembered they are likely to be deleterious and not beneficial to the patient. The author states that these agents (vasoconstrictors) have never been shown to improve the survival rate in any type of shock produced under controlled conditions.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Norman J. Barker, Collinsville

President-Elect, Mrs. E. Roland Hill, Mystic

First Vice-President, Mrs. Charles Murray Gratz, Cos Cob

Second Vice-President, Mrs. Morton Arnold, Windham Center

Recording Secretary, Mrs. Charles Culotta, Hamden

Corresponding Secretary, Mrs. James E. Stretch, Simsbury

Treasurer, Mrs. Joseph Cutler Woodward, South Lyme

The first board meeting of the year was held on July 10 at the home of the President, Mrs. Norman J. Barker, in Collinsville. All of the county presidents were present, a record we hope will continue to hold throughout the year. Future board meetings are scheduled for October 3, January 9 and March 5.

Civil Defense

In her report on Civil Defense, Mrs. Kenneth Brandon stated that "this need not be an age of fear. We can learn to live in the atomic era if we will take the time to understand a few basic facts and make some practical plans. Homemakers, business women and club women can lead the way in day to day living toward family and community understanding of 'Living with the H-Bomb'."

Public Relations

Mrs. Robert W. Nespor, chairman, said that radio programs on Medical Health were dropped for the summer but will be resumed in the fall.

Much work and time were put into helping with the medical health exhibits at county fairs. Pamphlets under discussion for distribution at these fairs included "First Aid," "You Can Get a Doctor," two about CMS. A new point of interest is that a farmer belonging to a Grange can, through his Grange, obtain CMS on a group basis.

County News

LITCHFIELD

The following chairmen have accepted appointment for 1955-56: AMEF, Mrs. James McKenna, Torrington; Finance, Mrs. I. S. Goldberg, Torrington; Historian, Mrs. Royal A. Meyers, Watertown; Hospitality, Mrs. Nicholas Samponaro, Litchfield; Membership, Mrs. Daniel P. Samson, Thomaston; Mental Health, Mrs. Jeffrey Ferris, New Milford; Program, Mrs. Clifford T. Conklin, Jr., Thomaston; Publicity, Mrs. Winfield E. Wight; Rural Health and Public Relations, Mrs. Andrew Orłowski, Torrington; *Today's Health*, Mrs. Frank D. Ursone, Norfolk.

A committee was organized by Mrs. Orłowski to man the seven Litchfield County fairs this fall.

MIDDLESEX

The following chairmen will head the county's committees this year: AMEF, Mrs. Mark Thumim; Art, Mrs. Vincent Vinci; Civilian Defense, Mrs. Hazen Calhoun; Historian, Mrs. Harry Knight; Hospitality, Mrs. Richard Grant; Legislation, Mrs. C. B. Crampton, chairman and Mrs. A. Thomson, Jr., co-chairman; Membership, Mrs. William Bauer; Nominating, Mrs. Willard Buckley; Parliamentary, Mrs. F. Erwin Tracy; Program, Mrs. Russell Lobb; Public Relations, Mrs. Joseph Epstein; Publicity and Press, Mrs. Harry Sherwood; Revisions, Mrs. Walter Nelson; School Health, Mrs. Clarence Harwood; *Today's Health*, Mrs. Andrew Turano; volunteer, Mrs. Stanley Alexander for the Children's Ward, Mrs. Charles Russman for the Darien Book Plan.

NEW LONDON

The first board meeting was held in May at the home of the President, Mrs. Hugh Lena, Jr. Plans were discussed for the Student Nurses Welfare and Scholarship Bridge and cake sale to be held in September. Mrs. Frederick Fagan and Mrs. Joseph Murray, Jr. are the co-hostesses.

WINDHAM

The following women will assume committee chairmanships during the coming year: Art, Mrs. Robert Bowen, Coventry; Civil Defense, Mrs. Robert Dinalt, Putnam; Historian, Mrs. Edward J. Ottenheimer, Windham Center; Hospitality, Mrs. Angelo J. Gulino, Plainfield; Legislation, Mrs. William M. Shepherd, Putnam; Medical and Surgical, Mrs. James Anderson, Windham Center; Membership, Mrs. Karl Phillips, Putnam; Nurse Recruitment, Mrs. Ralph Gilman, Storrs; Nurse Scholarship, Mrs. Sawyer Medbury, Windham Center; Program, Mrs. John Woodworth, Moosup; Publicity and Press, Mrs. Frederick A. Beardsley, Columbia; Public Relations, Mrs. William S. Maurer, South Windham; Revisions, Mrs. Morton Arnold, Windham Center; *Today's Health*, Mrs. J. Franklyn Jones, Danielson; Ways and Means, Mrs. Brice R. Valentine, Abington.

OBITUARY

James F. Rooney, M.D.

1879 - 1955



In the death of Dr. James F. Rooney, which occurred March 27, 1955 after a long illness, the medical profession of Hartford has lost a capable and worthy member.

He was born in Plainville, Connecticut April 2, 1879, a son of Timothy and Catherine Mullin Rooney. He attended St. Charles Seminary in Baltimore, Maryland, and was graduated from the University of Maryland Medical School in 1903. Dr. Rooney interned at St. Francis Hospital, became a member of the staff, and later the staff's president. During World War I he served as a captain in a French hospital.

Dr. Rooney was in general practice and a specialist in urology forty-five years. He served as school physician in several districts for many years.

I believe the field he most enjoyed was that of school physician where he could commune with children whom he dearly loved. His services as school physician was more a labor of love than a livelihood.

Dr. Rooney was a member of the Hartford Medical Society, the Hartford County Medical Association, the Connecticut State Medical Society, and the American Medical Association.

He was a true physician, and as such will long be remembered by a host of patients and friends. His wife, the former Catherine Ryan, died many years ago. Dr. Rooney is survived by a sister, Miss Susan Rooney of Plainville, with whom he made his home since 1948.

Michael J. Morrissey, M.D.

"An American Bookshelf" for Overseas

A representative of the U. S. Information Services stopped in at the AMA secretary's office the other day and promoted what appears to be a good idea to help counteract anti-American propaganda.

The agency, in cooperation with CARE, developed a project whereby a portable library of paperback books which we buy (for \$30) can be sent out (through CARE) to a designated library, school, institution, or individual in any of the hostile or neutral or amiable or curious corners of this earth.

The point of it all is to tell the true story of America and Americans to people abroad. And the nub of it is, of course, the kind of books that make up the bookshelf. The books reflect American ideals and culture and the plan is to help win people to the cause of true democracy.

Any physician who wishes to buy the bookshelf for someone abroad can contact CARE, 660 First Avenue, New York 16, New York.

The visitor also said that there are still many countries in need of books and journals in the field of medicine for libraries of medical schools and associations. Posts specifically requesting back issues of the *AMA Journal* are Rio de Janeiro, Managua, Madrid, Bangalore, Taipei, Beirut, and Tegucigalpa. Back files of medical journals and books should be mailed to: The U. S. Book Exchange, 1816 Half Street, S.W., Washington, D. C.

SPECIAL NOTICES

HARTFORD HOSPITAL, SATURDAY MORNING

11 O'CLOCK GUEST SPEAKERS

September 24 to December 10, 1955

September 24

Alfred Gellhorn, M.D., director of Cancer Research, The Francis Delafield Memorial Hospital, New York City
The medical management of malignant disease

October 1

S. J. Thannhauser, M.D., professor emeritus of medicine, Tufts College Medical School
Case presentations

October 8

Samuel Proger, M.D., professor of medicine, Tufts College Medical School, physician in chief, The New England Medical Center, president of the Bingham Foundation

Acute coronary disease without infarction

October 15

Alexander S. Nadas, cardiologist and associate physician, Children's Hospital, Boston, associate in pediatrics, Harvard Medical School

Congenital heart disease in children

October 22

Raymond D. Adams, M.D., chief of neurology and neuropathology, Massachusetts General Hospital

The neurologic problems presented by the alcoholic patient

October 29

C. N. H. Long, M.D., professor of physiology, Yale University School of Medicine

The new adrenal steroids

November 5

George J. Thomas M.D., chief of anesthesiology, St. Francis Hospital, Pittsburgh, Pennsylvania

Fires and explosions

November 12

Paul Young, M.D., associate professor of Ob-Gyn., Harvard Medical School and Women's Free Hospital, Boston

10:00 A. M. Pathology and treatment of CA in situ (cervix)

11:00 A. M. General aspects of CA in situ (cervix)

November 19

Garfield G. Duncan, M.D., professor of medicine, Jefferson Medical College, chief, Medical Division of the Pennsylvania Hospital

Practical aspects of diabetic management

November 26

Mr. Gordon L. Burke, USA, Foreign Service Officer (retired)

Chinese hygiene, habits, and customs

December 3

Howard A. Rusk, M.D., medical editor of the *New York Times*, chief of rehabilitation, Bellevue, New York University Medical Center; Medical Consultant to the Rehabilitation Division of the Veterans Administration and the United Nations

The dynamic approach to chronic disease

December 10

Averill Liebow, M.D., professor of pathology, Yale University School of Medicine

Clinical pathological conference

MEDICOLEGAL SYMPOSIUM

Statler Hotel, New York City, October 30, 1955

9:00 A. M. - 10:00 A. M.

Registration

10:00 A. M. - 10:15 A. M.

Opening remarks—welcome

10:15 A. M. - 10:45 A. M.

Areas of interest to doctors and lawyers

Louis J. Regan, M.D., LL.B., Los Angeles

10:45 A. M. - 11:10 A. M.

Not scheduled

11:10 A. M. - 12:00 NOON

Traumatic neurosis

Samuel Brock, M.D., New York City

12:00 NOON - 1:00 P. M.

Medical science in the administration of criminal justice

Richard Ford, M.D., Boston

1:00 P. M. - 2:00 P. M.

Lunch

2:00 P. M. - 2:30 P. M.

Medical expert testimony

Irving Goldstein, LL.B., Chicago

2:30 P. M. - 3:30 P. M.

Demonstration—Medical expert witness

Physician

Ralph E. DeForest, M.D.

Attorney (direct examination)

R. G. Van Buskirk, LL.B.

Attorney (cross examination)

Edwin J. Holman, LL.B.

(Participants—members of staff of American Medical Association)

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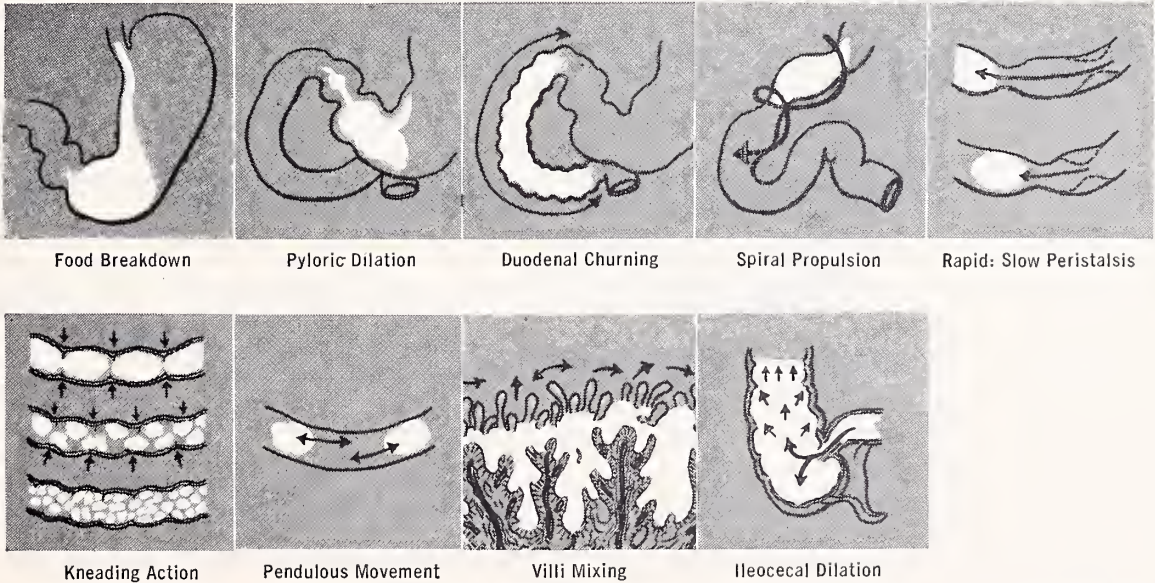
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TYPES OF MOVEMENT WITHIN THE BOWEL



3:30 P. M. - 5:00 P. M.

Open forum—written questions from those in attendance directed to any of the speakers at the morning or afternoon session

Sponsored by American Medical Association.

REGIONAL LEGISLATIVE CONFERENCE

New York City, Hotel Statler, October 29, 1955. Sponsored by American Medical Association.

AMERICAN HEART ASSOCIATION PLANS EXTENSIVE PROGRAM FOR ANNUAL MEETING AND SCIENTIFIC SESSIONS

The American Heart Association's 31st Annual Meeting and 28th Scientific Sessions in New Orleans, October 22-28 will present the most extensive and varied program ever conducted by the Association.

The Scientific Sessions and the programs of the Council on Community Service and Education and of the Council on Rheumatic Fever and Congenital Heart Disease will be conducted at the New Orleans Municipal Auditorium, October 22-24. Other events, including the annual meeting of the Assembly, top governing body of the Association, will be held at the Jung Hotel.

Included on the scientific program will be general morning sessions and concurrent afternoon sessions of specialized interest to members of the various sections and councils of the Heart Association including the Sections on Clinical Cardiology, Cardiovascular Surgery, Circulation and Basic Science (jointly), and the Council for High Blood Pressure Research.

In addition, there will be a program on rheumatic fever prevention and problems of cardiac children in the schools under the joint auspices of the Council on Rheumatic Fever and Congenital Heart Disease and the Council on Community Service and Education. The Community Service Council will also offer a program encompassing rehabilitation and the relationship between body weight and heart disease.

SPECIAL LECTURES

Two special lectures have been scheduled. The Lewis A. Conner Memorial Lecture on Saturday, October 22, and the George Brown Memorial Lecture on Sunday, October 23. The Conner Lecture will be presented by George A. Perera, M.D., associate professor of medicine at the Columbia University College of Physicians and Surgeons. His subject will be Primary Hypertension. George Burch, M.D., Henderson professor of medicine at Tulane University School of Medicine, will give the Brown Lecture on the subject of Digital Rheo-Plethysmography.

A special program will be another feature of the Scientific Sessions. A wide range of commercial exhibits will be shown, and arrangements are now being made for the inclusion of a limited number of scientific exhibits.

NONMEMBERS WELCOME

Attendance at the Scientific Sessions is open to nonmembers as well as to Heart Association members. A moderate registration fee will be charged to nonmembers. This fee will enable them to receive the printed proceedings. Medical students, interns, residents, research workers and nurses will be welcome at the sessions without charge. Registration forms, which contain provisions for reserving hotel accommodations, can be obtained from local Heart Associations and from the American Heart Association, 44 East 23rd Street, New York 10, N. Y.

AMERICAN MEDICAL WRITERS' ASSOCIATION 12th ANNUAL MEETING

Hotel Jefferson, St. Louis

(Nearest large city to center of population of U. S.)

September 30, 1955; Workshop, October 1

Speakers, A.M.W.A. Meeting, September 30

James E. Bryan, PH.B., Summit, N. J., author, "Public Relations in Medical Practice"

Preparation of public relations material

Donald C. Collins, B.A., M.D., M.S., SC.D., F.A.C.S., Hollywood, California, assistant professor of surgery, College of Medical Evangelists

Preparation of medical articles for publication

Earl English, B.F.A., B.S., M.A., PH.D., Columbia, Missouri, dean, School of Journalism and professor of journalism, University of Missouri

Report on medical journalism programs—Illinois, Missouri, and Oklahoma Universities

Joseph Garland, B.A., M.D., D.Sc., Boston, Massachusetts, editor, New England Journal of Medicine

Clarity in medical writing

Oeveste Granducci, B.S., Washington, D. C., free lance script writer

How to write scripts for medical motion pictures

J. P. Gray, B.A., M.D., M.P.H., Detroit, Michigan, visiting lecturer on medical writing, A.M.W.A.

Report on A.M.W.A. visiting lectureship to the medical colleges

Elmer Hess, M.D., F.A.C.S., Erie, Pennsylvania, president, American Medical Association; principal banquet speaker; editor, Urologic Section

Encyclopedia of medicine, surgery, and specialties

Richard Hewitt, B.A., M.A., M.D., Rochester, Minnesota, associate professor of medical literature, Mayo Foundation University of Minnesota

Report of A.M.W.A. educational committee; coordinator of Workshop on Medical Writing

Charles E. Lyght, M.D., M.C., F.A.C.P., Rahway, N. J. editor, Bulletin, A.M.W.A.

Discussion leader



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Theodore Peterson, B.A., M.S., PH.D., Urbana, Illinois, associate professor, School of Journalism and Communications, University of Illinois

Report of A.M.W.A. manuscript editing service

Raymond C. Pogge, B.S., B.M., M.D., Cincinnati, Ohio, director of Medical Research, Wm. S. Merrell Co.

Discussion leader

Dean F. Smiley, B.A., M.D., Chicago, Illinois, editor, Journal of Medical Education

Moderator of symposium on preparation of medical articles

Harold Swanberg, B.S., M.D., F.A.C.P., Quincy, Illinois, editor, Mississippi Valley Medical Journal Radiologic Review

Report of A.M.W.A. manuscript editing service

Alan E. Treloar, B.S.A., M.S., PH.D., Minneapolis, Minnesota, professor of biostatistics, University of Minnesota

Do statistics clarify or confuse?

Lee D. Van Antwerp, B.A., M.D., F.A.C.P., Chicago, president, American Medical Writers' Association

Moderator of symposium on A.M.W.A. services

Benjamin B. Wells, B.S., M.D., PH.D., F.A.C.P., Omaha, Nebraska, professor and director, Department of Medicine, Creighton University

Preparation of medical textbooks

Speakers, A.M.W.A. Workshop on Medical Writing, October 1

Richard Hewitt, B.A., M.A., M.D., Rochester, Minnesota, coordinator; senior consultant, Section of Publications, Mayo Clinic

Conducted by members of journalism faculties
University of Missouri, University of Oklahoma, University of Illinois

Paul Fisher, B.A., B.J., M.A., PH.D., Columbia, Missouri, School of Journalism, University of Missouri

From first draft to printed page

Stewart Harral, B.A., M.A., Norman, Oklahoma, School of Journalism, University of Oklahoma

Specific devices for increasing the readership of medical articles

Theodore Peterson, B.A., M.S., PH.D., Urbana, Illinois, School of Journalism and Communications, University of Illinois

Writing for the lay reader

All physicians and collegiate graduates interested in medical writing, journalism or publishing are cordially invited and urged to attend the meeting and to become Association members. There is no registration fee for attending the meeting, but nonmembers will pay a \$5 registration fee for the Workshop. A complete, detailed program will be available about September 1.

American Medical Writers' Association: Lee D. van Antwerp, B.A., M.D., F.A.C.P., Chicago, president; Harold Swanberg, B.S., M.D., F.A.C.P., Quincy, Illinois, secretary.

Headquarters, 209-224 W.C.U. Building, Quincy, Illinois, U. S. A.

FLOODS CANCEL INDUSTRIAL HEALTH SYMPOSIUM

The Industrial Health Symposium scheduled for September 22 at the United States Rubber Company, Footwear Division, in Naugatuck, has been cancelled because of flood conditions.

The symposium had been planned by the Committee on Industrial Health, Connecticut State Medical Society.

AMERICAN COLLEGE OF SURGEONS 41st ANNUAL CLINICAL CONGRESS

Conrad Hilton Hotel, Chicago
October 31 - November 4, 1955

EVENING SCIENTIFIC SESSIONS

Monday, October 31, 8:30 P. M.

Martin Memorial Lecture, Grayson L. Kirk

Friday, November 4, 8:30 P. M.

Convocation

Presidential Address, Warren H. Cole

GENERAL SESSIONS

Monday, October 31

Panel: Surgery of the thyroid, 10:00 A. M.

Richard B. Cattell, Moderator

Clinicopathology Conference, 1:30-3:00 P. M.

Edwin F. Hirsch, Moderator

Panel: Parenteral therapy, 3:30-5:00 P. M.

Carl A. Moyer, Moderator

Tuesday, November 1

Panel: Carcinoma of the breast, 1:30-3:00 P. M.

Clarence E. Gardner, Jr., Moderator

Symposium on trauma, 2:00-5:00 P. M.

R. Arnold Griswold, Chairman

Panel: Surgery in patients with cardiac disease

3:30-5:00 P. M. Charles J. Johnston, Moderator

Wednesday, November 2

Panel: Surgery and anesthesia, 1:30-3:00 P. M.

Frank Gerbode, Moderator

Symposium on cancer, 2:00-5:00 P. M.

Danely P. Slaughter, Chairman

Panel: Benign lesions of the pancreas, 3:30-5:00 P. M.

John H. Mulholland, Moderator

Thursday, November 3

Panel: Surgery of the colon, 1:30-3:00 P. M.

Claude F. Dixon, Moderator

Trauma oration, Frank B. Berry

"Mass casualties," 2:00 P. M.

Friday, November 4

What's new in surgery? 9:00-12:00 noon

Harris B. Schumacker, Jr., presiding

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SURGICAL SPECIALTIES

NEUROLOGICAL SURGERY

Thursday, November 3

Symposium on management of facial pain, 9:00 A. M.

Bronson S. Ray, Moderator

Symposium on surgical management of upper extremity pain, 10:30 A. M.

E. S. Gurdjian, Moderator

UROLOGY

Tuesday, November 1

Panel: Management of undescended testes, 1:30-3:00 P. M.

Norris J. Heckel, Moderator

Wednesday, November 2

Panel: Management of prostatic hypertrophy, 3:30-5:00 P. M.

Victor F. Marshall, Moderator

Thursday, November 3

Panel: Management of renal lithiasis, 1:30-3:00 P. M.

Charles C. Higgins, Moderator

Friday, November 4

Panel: Evaluation of supradradical surgery in malignant disease of the lower abdomen and pelvis (Joint Specialty Session), 1:30-3:00 P. M.

Eugene M. Bricker, Moderator

GYNECOLOGY AND OBSTETRICS

Note: This program has been enlarged this year to meet the demand for inclusion of a larger number of sessions devoted to subjects in obstetrics

Monday, October 31

Panel: The place of the D & C in gynecology, 1:30-3:00 P. M.

Lewis C. Scheffey, Moderator

Panel: Cesarean section, 3:30-5:00 P. M.

Curtis Tyrone, Moderator

Tuesday, November 1

Panel: Conservation of ovarian tissue, 1:30-3:00 P. M.

John McLean Morris, Moderator

Panel: Estimation of pelvic size, 3:30-5:00 P. M.

M. Edward Davis, Moderator

Wednesday, November 2

Panel: Blood clotting problems in obstetrics, 1:30-3:00 P. M.

Duncan E. Reid, Moderator

Panel: Studies in the radiosensitivity of tumors, 3:30-5:00 P. M.

Saul B. Gusberg, Moderator

Thursday, November 3

Surgical forum reports in gynecology and obstetrics, 1:30-3:00 P. M.

Friday, November 4

Panel: Hazards of fetal existence, 1:30-3:00 P. M.

John Parks, Moderator

Panel: Care of patient under radiation therapy, 3:30-5:00 P. M.

Herbert E. Schmitz, Moderator

ORTHOPEDIC SURGERY

Friday, November 4

Panel: Fractures of the lower end of the radius and fractures of the carpal bones—diagnosis, treatment, prognosis, 9:00-10:30 A. M.

Jesse T. Nicholson, Moderator

Panel: Differential diagnosis and treatment of neck, shoulder and arm pain, 1:30-3:00 P. M.

Joseph A. Freiberg, Moderator

THORACIC SURGERY

Friday, November 4

Panel: Management of emphysematous blebs and spontaneous pneumothorax, 1:30-3:00 P. M.

Moderator to be announced

Panel: Recent developments in cardiac surgery, 3:15-4:45 P. M.

Willis J. Potts, Moderator

PLASTIC SURGERY

Friday, November 4

Panel: Tissue banking and skin preservation, 9:00-10:30 A. M.

Moderator to be announced

Panel: Carcinoma of the face, mouth, jaw and neck, 1:30-3:00 P. M.

William F. MacFee, Moderator

OTOLARYNGOLOGY

One evening session only, due to meeting of American Academy of Ophthalmology and Otolaryngology in Chicago prior to Congress. Program and time to be announced.

OPHTHALMOLOGY

See above. Program and time to be announced.

FORUM ON FUNDAMENTAL SURGICAL PROBLEMS

There will be sixteen surgical forum sessions this year. The program will again include one or more sessions for five special fields of surgery. Monday through Friday, mornings and afternoons. Harris B. Shumacker, Jr., Chairman.

POSTGRADUATE COURSES AND CHAIRMEN

Courses will meet Monday through Thursday, except Ob-Gyn, which meets Monday through Friday. All courses: 8:30-11:30 A. M.

Pre- and postoperative care

Henry N. Harkins

Gastrointestinal tract

John D. Stewart

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The direction circular included in all packages of Bayer Aspirin has recently been published in full pages in leading national magazines reaching well over seventy-five million. Quoted below is a prominent paragraph from these directions.

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Hand injuries

Michael L. Mason

Obstetric and gynecologic surgical care

John I. Brewer

Malignant bone tumors

Murray M. Copeland

Surgical aspects of pulmonary disease

Herbert C. Maier

COLOR TELEVISION — CINE CLINICS — MOTION PICTURES

Color television, with two-way audience communication, is a new feature of this year's program. Audiences may listen to the discussion of operating surgeons at the scene, and ask questions. Program will originate from the University of Illinois College of Medicine Research and Education Hospital. Monday through Friday, 9:00-11:30 A. M.

Cine clinics, showing significant surgery throughout the United States. Tuesday through Friday, 8:30-12:30 P. M.

Motion pictures each morning and afternoon, with the popular Motion Picture Symposium on Wednesday evening, 8:30 P. M.

GRADUATE TRAINING SYMPOSIUM

Symposium on graduate training in surgery and the surgical specialties. Thursday, 2:00 P. M. Frederick A. Collier, Chairman.

NEWS

from County Associations

Fairfield

The Wee Burn Country Club, Darien, will be the site of the Semi-Annual meeting of the Fairfield County Medical Association on Wednesday, October 5, according to an announcement by J. Donald Corridon, South Norwalk, vice-president. The business session is scheduled for midafternoon, followed by a social hour and dinner. The speaker for the occasion has not been made known.

The Public Relations Committee of the Fairfield County Medical Association has selected the exhibit "You Can Reduce" for its display at the Danbury Fair, October 1-9, inclusive. This marks the second consecutive year in which the Association will be represented at Danbury Fair. A call for volunteers to man the exhibit has been made by the Association.

The finals of the Fairfield County Medical Golf Association are scheduled for Wednesday, Septem-

ber 14 at the Wee Burn Country Club, Darien. Matches will be followed by a dinner, prize awards and election of officers of the golfing organization.

Hartford

George G. Keefe of Hartford, chief of the Department of Medicine at St. Francis Hospital for 15 years, died on July 21 in that hospital at the age of 50 years.

At the recent annual meeting of the New Britain Memorial Hospital Henry W. Kraszewski was elected president of the medical staff. Dr. Kraszewski, a New Britain native, is a graduate of Dartmouth College and Tufts Medical School. He is secretary of the New Britain Medical Society. Alfred Berger was also elected vice-president and Francis S. Buchcheri, secretary. Mario Yanello replaced Philip Moorad on the executive committee. Dwight Bernstein was outgoing president.

Recently Yale University Medical School promoted from assistant professor to associate professor of medicine David N. Shulman of Hartford. He has also been appointed attending physician to the Grace-New Haven Memorial Hospital.

At the June 28 meeting of the Hartford County Chapter of the Academy of General Practice, Norman D. Markley of Hartford was elected president. Vice president and president elect is Joseph Raffa of Glastonbury. Elected as treasurer is John M. Monacella of Windsor and for secretary, Siegfried S. Schatten of West Hartford. Joseph Massaro of Manchester was elected to the chapter's board of directors.

J. Whitfield Larrabee has been elected president of the Connecticut Rheumatism Society.

Founders to the new Connecticut Society of American Board Internists are Edward Nichols and Benjamin V. White of Hartford and John C. White of New Britain.

William J. Lahey, president of the Hartford TB Society, in July thanked HCMA's 52 physicians for their response to the follow-up of 102 persons whose chest x-rays indicated further investigation during the society's Hartford casefinding campaign last May. Dr. Lahey said that most of these physicians responded to questionnaires requesting final diagnosis. He asked that those who have not yet returned their replies to do so.

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(1) Poyne, R. W.; Shetlar, M. R.; Farr, C. H.; Hellbaum, A. A., and Ishmael, W. K.: J. Lab. & Clin. Med. 45:331, 1955. (2) Bunim, J. J.; Williams, R. R., and Black, R. L.: J. Chron. Dis. 7:168, 1955. (3) Holbrook, W. P.: M. Clin. North America 39:405, 1955.

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chester Mental Health Society. The group has agreed, as its first step, to set up eight committees toward preliminary organizations. The society will focus on community education in the mental health area and work towards the eventual establishment of a psychiatric clinic to give diagnostic and treatment service. Francis Helfrick and Howard Boyd spoke at the formation meeting.

Roswell Johnson, president of the Board of Directors of New Britain's Mental Hygiene Society, described the workings of his child guidance clinic to the new association. He pointed out the realities that must be faced in establishing a clinic, the difficulty of obtaining trained child psychiatrists and the importance of adequate financing.

Middlesex

After we went to press with the last issue a fourth intern reported for duty at the Middlesex Memorial Hospital. He is Joseph Manzi, a graduate of the University College of Cork Medical Faculty, Cork, Ireland.

David Harvey has joined his father, Carl Harvey, and his brother Sanford in their office. He will do general practice.

Earl Patterson, one of last year's interns at the Middlesex Memorial Hospital, has just begun a residency in psychiatry at the Connecticut State Hospital.

Donn Barton, who has been practicing in Middletown for a year, has moved his office to 506 Main Street, Portland where he will continue in general practice.

Charles W. Chace, another of last year's interns, has begun general practice in Middletown in association with Henry Sherwood.

Anton Lethin, Jr. has accepted an appointment as a pediatrician at the Kaiser Foundation in San Francisco, California.

New London

The Charles Pfizer Company, Inc., were hosts to a physicians golf outing at the Shennecossett Country Club, Groton, Connecticut on Wednesday, July 20. The Groton plant acted as hosts at a buffet dinner at the Pfizer Club House following the golf outing. The following doctors won prizes: low gross, Fred Fagan; low net, S. Paul Tombardi; most birdies, Charles Krinsky; high gross, Eric Blank; high hole, Clifford Wilson; longest putt, Casimer Bielecki; nearest approach, H. Irwin; lowest hole, prize shared by Bud Goodrich, Hiliard Spitz, Fred

Andersen, and Fred Barrett; highest on nine holes, Robert Olsen; birdie on the fifth, Harold Raymer and Mario Albamonti.

The affair was a huge success and we hope that next year there will be a golf match between the Norwich and New London physicians.

The annual meeting of the New London Heart Chapter was held on June 29 at the Mayfair Restaurant on Boston Post Road, Waterford. At the meeting it was decided to send three worthy children to camp for the summer, and money was set aside to provide further diagnostic equipment for testing pulmonary function. The new officers for the coming year will be Harold Irwin, president, and Joseph Wool, president elect.

Bernard Beatman, M.D. wishes to announce the opening of his office at 34 Channing Street, New London for the practice of pediatrics.

Homicides Decreasing

During the past two decades the homicide rate in the United States, except for short periods following World War II and the Korean War, has been steadily decreasing according to a recent issue of the *Statistical Bulletin* of the Metropolitan Life Insurance Company. In spite of this continued downward trend which shows no signs of abatement in 1955, homicide continues to be a major cause of death among nonwhite males, the rate in this group being 21.7 per 100,000 in 1952-54, or more than 11 times that for white males. On the distaff side the rate among nonwhites was seven times that for whites and about three times the white male rate. There is a definite trend from the third decade to the fifth in males and from the third to the fourth decade in females.

The highest homicide rate appears to exist in the South and the lowest in New England and this is true of whites as well as nonwhites. The majority of the homicides are the result of the use of firearms. This country makes a very poor showing in the total number of homicides—more than 7,500 annually—when compared with other countries with a cultural background. The homicide rate of the white population in the United States is more than twice the rate in Canada and Australia, about three times that in Scotland, and about six times that in England and Wales, and Ireland.

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Bumbalo, T. S., Gustina, F. J.,
and Oleksiak, R. E.:
J. Pediat. 44:386, 1954.

White, R. H. R., and
Standen, O. D.:
Brit. M. J. 2:755, 1953.

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Brown, H. W.:
J. Pediat. 45:419, 1954.

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NEW BOOKS IN REVIEW

THE CLINICAL INTERVIEW. Volume II. Therapy (A Method of Teaching Sector Psychotherapy.) By Felix Deutsch and William F. Murphy. New York: International Press, Inc. 1955. 335 pp. \$7.50.

Reviewed by FRANCIS J. BRACELAND

The first volume of The Clinical Interview series by the same authors was directed toward teaching residents how to apply their insights in clinical interviews. It discussed the technique which the authors call "associative anamnesis," which is based upon free associations as they are used in analysis. This present volume is a logical companion piece to the first. It deals with what is called "sector psychotherapy," which is based upon interviews gleaned by the technique described above.

Sector psychotherapy is a method of approach to the neuroses in which the therapist attacks one symptom or set of symptoms at a time, realizing that the changes in the whole individual will be much more widespread than is apparent. The problems peculiar to the various phases of the therapeutic situation, such as the isolation of a sector, the continuity of interviews, the problems of reticence or verbosity in the patient in the interview situation, plus the important process of termination of treatment, are all discussed in detail and examples of the technique given.

Much of the book is concerned with a verbatim recording of various interviews interspersed with comments of the

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therapist as to the meaning of the patients' productions. These reports demonstrate the authors' method of bringing to the patient's awareness the unconscious motivations of his illness. For psychotherapy to be of value it is necessary for the patient to be able to understand the significance of these past events in terms of the present. Unfortunately this cannot be satisfactorily accomplished by rational discussion nor philosophical musing.

Throughout the work the writers demonstrate their facility in the art of interviewing. Through the medium of the patients' own productions, accented and repeated back to them at regular intervals, various problems are brought to light, as are the relationships between past and present. The difficult art of listening, as practiced by expert therapists, is in evidence throughout the interviews. Withal, however, the therapist is in complete control of the situation.

The book is intended for psychiatric residents and those in the fields allied to psychiatry, but the work could be read with profit by anyone who is interested in the complex problems which are manifested in therapeutic relationships.

SWIFT AND CARROLL. *A Psychoanalytic Study of Two Lives.* By Phyllis Greenacre, M.D. New York: International Universities Press. 1955. 305 pp. \$5.

Reviewed by FRANCIS J. BRACELAND

The author, Dr. Greenacre, is a practicing psychoanalyst who writes easily and well. In this volume she examines the lives of two men, Jonathan Swift and Lewis Carroll (Charles L. Dodgson), both of whom wrote English classics.

At first sight it would seem that one would have trouble in coupling two such disparate characters, Swift a man of the world, irascible, difficult, revengeful and sometimes ribald, Carroll quiet, retiring, shy, an Oxford Don. Both were British, both theologians, both unmarried and, as the author points out, both passionately disliked babies. Swift took sides in political controversies; Carroll wrote nonsense for little girls whom he liked. Fussy and pedantic as was the latter, he came out of himself as he entertained little girls with delightful nonsense. Under the author's careful scrutiny the basic sameness of both authors is brought to light.

Though written for psychoanalysts, other physicians will find the book interesting. The author is well informed and aware of the pitfalls of diagnosing history and biography. She has assembled a wealth of material and handles it well. Men who were raised on Gulliver and Alice will appreciate this pathographic study.

PEDIATRIC DIAGNOSIS. By Morris Green, M.D., Assistant Professor of Pediatrics, Yale University School of Medicine and Julius B. Richmond, M.D., professor and Chairman of the Department of Pediatrics, State University of New York College of Medicine at Syracuse. Philadelphia: W. B. Saunders Co. 1954. 436 pp. \$10.

Reviewed by EDWARD T. WAKEMAN

This book is designed primarily for students and practitioners to improve their diagnostic skill in the care of children. It is not a textbook of pediatrics nor does it discuss treatment. It is not primarily a reference book but more particularly a book to teach. The emphasis is on "competence in history taking and physical examination; on the

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accomplishment of early diagnosis; on the application of information from the basic sciences to clinical situations; on the development of a functional knowledge of physical, physiologic and psychologic growth and development; and on differential diagnosis."

There is a tremendous amount of factual information. More than simply listing the conditions in which a particular sign or symptom occurs, there is liberal discussion of the origin or physiology of the sign or symptom and consideration of the diseases or conditions in which such signs or symptoms are commonly found. These discussions are documented with many references incorporated in the text.

Davison's, "The Compleat Pediatrician" is useful in providing a check list for given signs or symptoms. Slobody's, "Survey of Clinical Pediatrics" is excellent in its synoptic treatment of pediatric diseases. Although this volume also provides a check list and some description of disease, it is oriented toward acquisition of knowledge through history and physical examination and the application of this knowledge to diagnosis.

One feature of this book deserves comment. There is a section on Health Supervision which reflects the author's conviction that "evaluation of the presumably healthy child requires the same considered diagnostic approach as that applied to the evaluation of symptoms related to disease" and "that the guidance of the growth and development of children can be fully as interesting and gratifying as the care of the sick child."

The Appendix tabulates percentiles for weight and length and certain selected measurements from birth to eighteen years.

For self teaching this book is excellent. It is inconceivable that careful reading of these pages would not improve thoroughness of observation and interpretation of signs and symptoms in health and disease. This book admirably meets the objective toward which it was written, namely, "to improve . . . diagnostic skill in the care of children."

AGEING—GENERAL ASPECTS. Ciba Foundation Colloquia on Ageing. Vol. 1. Boston: Little, Brown & Co. 665 pp. \$5.

Reviewed by JAMES R. MILLER

If the Ciba Foundation Colloquia on Ageing, in subsequent volumes, continue to produce such interesting and significant reading material as in Volume 1, those who are interested in the scientific problems of ageing will be fortunate indeed and the Ciba corporation may be proud of its offspring. For here are grouped in convenient manner such considerations as the definition and measurement of senescence, the mental aspects of ageing, its effects on respiratory function, calcium and steroid metabolism, changes in elastic tissue and the blood vessel lesions of the skin. Here one may read of transplantation techniques, the preservation of tissues, and the problem of suspended animation, all considered from a fresh and hitherto poorly explored point of view, namely, the changes due to ageing as such apart from disease.

The best part of most medical meetings is likely to be the discussion period, provided there are fertile minds present who speak freely and also, which is important for

the written record, provided careful editing has winnowed the chaff. This has been done. Considering the international aspect of the meeting, the reader will be grateful.

Interesting bits linger in the reviewer's mind. Oogenesis is still considered to stop after birth. That is one item that we do not have to unlearn. Too early maturation of children is one cause of ageing. Chess champions are always young, rarely over 35. And it is interesting to know that the traits commonly recognized as "characteristic" of elderly people are merely underlined features of individual personality. In other words it is easier to see in old age what kind of a person one has been all along, be it a kindly, gentle soul or a crotchety old "so-and-so."

This volume will interest many different scientific minds as well as (pardon the expression) the gerontologist. Here is interest for the family physician, the internist and the psychiatrist as well as the nutritionist, the pathologist and pediatrician. Many a reader, like the reviewer, will find himself over his depth at times but it is good to know what kind of discussions take place in the lee of a great gerontological congress. A few charts and illustrations, good editing and excellent typography make all this easy to take.

One useful definition offered by Albertini seems especially pithy. "Ageing is the manifestation of decreasing adaptation caused by loss of tissue and functional reserve."

PERIPHERAL VASCULAR DISEASES. Second Edition.

By Edgar V. Allen, B.S., M.A., M.D., M.S., in Medicine, F.A.C.P. Section of Medicine, Mayo Clinic; Nelson W. Barker, B.A., M.D., M.S. in Medicine, F.A.C.P. Section of Medicine, Mayo Clinic; Edgar A. Hines, Jr., B.S., M.A., M.D., M.S. in Medicine, Section of Medicine, Mayo Clinic. Philadelphia and London: W. B. Saunders Company. 825 pp. 1955. \$13.

Reviewed by THEODORE S. EVANS

Drs. Allen, Barker, Hines and associates at the Mayo Clinic have presented the important contributions to and present attitudes on a large number of vascular diseases in a most interesting fashion. The book is beautifully bound, and its 825 pages contain practically everything on the subject. The print is large and easy to read. The 315 illustrations, 7 of which are in color, are excellent. I particularly liked the discussion on Raynaud's syndrome and related diseases. A very interesting discussion on temperature changes contained much that was new to me. The chapters on thrombocytopenic purpura leave something to be desired in that some of the most celebrated authorities on the subject are not mentioned.

The one possible adverse criticism is the one which is always inevitable when a single group produce a volume on a very widespread and controversial subject, i.e., there is a definite tendency to present the material from a somewhat limited point of view.

The method of presentation is particularly charming since a brief historical, pathological, physiological and clinical description is given of each disease. The book should prove to be of interest to any individual in the medical field, whether he be an investigator or clinician, and I think should be on the shelves of all of us.

THE USE OF DISULFIRAM (ANTABUSE)

In the Comprehensive Therapy of a Group of 1,020 Alcoholics

EBBE CURTIS HOFF, M.D., *Richmond, Virginia*

CHRISTOPHER FRY's new play, "The Dark Is Light Enough," takes its title from Fabre's description of the passage of a lovely butterfly across a dark woodland. "The weather was stormy," he writes, "the sky heavily clouded; the darkness . . . profound . . . It was across this maze of leafage, and in absolute darkness, that the butterflies had to find their way in order to attain the end of their pilgrimage . . . The butterfly . . . goes forward without hesitation . . . So well it directs its tortuous flight that, in spite of all the obstacles to be evaded, it arrives in a state of perfect freshness, its great wings intact . . . The darkness is light enough . . ."

Without security, without promise, Fabre's butterfly successfully makes its transit across the darkness and the darkness provides, even though dimly, the clues the frail, delicate creature needs. Within Fry's play, the Countess Rosmarin Ostenburg emerges as such a creature, reacting successfully to life in spite of danger, dispossession, and finally the imminence of death. This sensitive, appropriate interaction between living organisms and the environment fills us with awe and wonder and yet the most naive, superficial observer of life soon finds himself confronted with another, infinitely more sombre, but no less real, aspect. What of those for whom the darkness is *not* light enough? Such a one—in Fry's play—is Richard Gettner. Into Gettner's mouth the playwright puts these words:

"Is there another
Word in the language so unnecessary
As 'fail' or 'failure'?
No one has ever failed to fail in the end:
And for the very evident reason
That were made in no fit proportion
To the universal occasion; which, as all

The Author. *Professor of Neurological Science, Medical College of Virginia, Richmond, Virginia, and Medical Director, Division of Alcohol Studies and Rehabilitation, Department of Health, Commonwealth of Virginia*

SUMMARY

Alcoholics do not present any single typical pattern of symptoms and behavior. The disease represents a symptom of such a diverse collection of human beings that interest has been aroused on the part of biological scientists, clinical psychologists, social workers, internists and psychiatrists in collaborated effort to render assistance.

Disulfiram (Antabuse) was used on a total of 1,187 alcoholics. The following report covers results of studies on 1,020 patients with 484 controls. The dosage program is outlined and the various reactions described. The results obtained from this treatment are analyzed. Four tables illustrate the text.

Children, poets and myth-makers know,
Was made to be inhabited
By giants, fiends, and angels of such size
The whole volume of human generations
Could be cupped in their hands."

In these movingly beautiful poetic lines Fry has expressed a problem tormenting many a person harrassed with his own sense of inadequacy, his fears, anxieties, compulsions, guilt, depression or hostility. Not inappropriately, Gettner has recourse to drink in the playing of his part. Not every mentally or emotionally troubled person becomes an alcoholic, of course, and not every alcoholic presents a clearly discerned pre-alcoholic history of

mental or emotional disturbance. In fact, though alcoholics are a ubiquitous group in a judge's court, a personnel counselor's or clergyman's study, or in a physician's practice, they do not reveal a single, typical pattern of physiological, psychological or social symptomatology and behavior. Alcoholism stands out as a unifying symptom in a diverse collection of human beings whose sickness is protean, complex, and often intractable. The modern interest in the care of alcoholics and the dynamics of alcoholism has inspired serious efforts at classification of this baffling group of unhappy folk, study of their possible physiological, biochemical and psychic peculiarities, and special techniques for their rehabilitation. This interest has brought together basic biological scientists, clinical psychologists, social workers, internists and psychiatrists in collaboration. Much has been learned. There have been many failures and some successes—enough of both to encourage further endeavor, enough to commend the value of a comprehensive, many faceted attack upon the problem.

The purpose of this paper is to report briefly upon the use of the drug disulfiram (Antabuse) in our own attempts to offer a comprehensive plan of therapy to alcoholics. (In the Division of Alcohol Studies and Rehabilitation in Virginia, we accepted between November, 1948 and August, 1954 a total of 1953 patients, all admitted to our Service at the Medical College of Virginia on a voluntary basis. Between June, 1949 and August, 1954 we offered disulfiram as an adjunct in the treatment of 1,187 patients who volunteered to take this drug. The present report concerns 1,020 of these disulfiram patients (922 males and 98 females) admitted to the Service between June, 1949 and November, 1953 and 484 control alcoholic patients (421 males and 63 females) who were accepted in the Service during the same period and were exposed to the same therapeutic plan except that they did not receive disulfiram.)

TYPE OF PATIENTS TREATED

As stated, all patients were admitted voluntarily and were not given disulfiram unless they so requested. All presented histories of progressively serious difficulties related to uncontrolled drinking, usually for several years. Most had received previous treatment for alcoholism in private sanatoriums, State hospitals or from private physicians. Most had been drinking heavily within a day prior to admis-

sion.) Thirty-one and one-tenth per cent were referred by physicians, 23.1 per cent by courts, social agencies, clergymen and Alcoholics Anonymous, and 35.8 per cent by family, friends, or others. Ten per cent were self referred. The therapeutic plan included initial hospitalization for one to two or more weeks followed by outpatient care in our clinics for at least a year. All patients received medical, psychological, psychiatric and social work-up as indicated. Therapy included necessary medical care as well as group therapy during the hospital stay and individual psychotherapy and other care in the outpatient clinic. Job placement and other elements of social rehabilitation were attempted when needed and members of the family, employers, clergymen, or other concerned persons were drawn into the treatment program when this was thought desirable and the patient was agreeable.

LABORATORY TESTS

We did not offer disulfiram to patients with serious renal, hepatic, cardiac, pulmonary or metabolic dysfunction and also eliminated from the disulfiram series those patients with obvious mental deterioration, or psychoses. All patients received liver function tests, including cephalin-cholesterol flocculation, bromsulphthalein, serum bilirubin, and thymol turbidity tests. Renal function tests included urinalysis, phenolsulfophthalien test, blood urea nitrogen, and 12 hour Mosenthal test. Complete blood counts and serology were done routinely. Every patient received a chest x-ray and an electrocardiogram. Fasting blood sugar was measured in all patients. Patients received psychometric tests and electroencephalograms as well as other test procedures as indicated. Less than 20 patients were denied disulfiram on psychological grounds. The majority of patients who were disqualified for disulfiram were denied the drug on the basis of inadequate liver function.

PROGRAM OF TREATMENT

All of our patients were started on disulfiram while in hospital. This included one disulfiram-alcohol reaction test. Some investigators initiate disulfiram as an outpatient procedure and increasingly the planned reaction test is being eliminated by many. Others plan several reaction sessions in the course of inpatient treatment. In our own schedule, disulfiram is given in an amount of 1.5 Gm. initially (usually about the 5th or 6th day after admission), 1.0 Gm. the next day and 0.5 Gm. on the 3rd and

4th days. With this dosage, side reactions are absent or very moderate. Larger doses during the 4 day pre-reaction stage may cause lower abdominal cramps, headache, dizziness, or nausea. Initial side reactions tend to occur more frequently in patients with poor motivation and those who are anxious about the reaction test. On the 4th day after starting disulfiram, the patient rests supine for one-half hour in bed and is then given a dose of 86 to 90 proof whiskey. In our earlier use of disulfiram we gave as much as 50 or 60 cc. but the reactions were so severe as to make it desirable that patients remain in the hospital thereafter for one or two days longer. We accordingly reduced the dosage to 30 cc. or less which gives what we consider to be a satisfactory reaction. A physician or nurse remains with the patient during the entire reaction and checks blood pressure, pulse, and respiration every five minutes. We have not followed the plan of administering reactions in groups nor is there formalized psychotherapeutic contact with the patient during the reaction. The meaning of the reaction experience to the patient is, however, integrated into subsequent therapeutic planning for him.

DISULFIRAM-ALCOHOL REACTION

The disulfiram-alcohol reaction is well known and need only be briefly described here. In the moderately severe reaction there is a fall in systolic and diastolic pressures of 20 to 60 mm. Hg and a corresponding rise in the pulse rate to about 120 per minute, usually with a rise in respiratory rate. These cardiovascular-respiratory changes occur in response to a generalized skin vasodilatation developing within 5 to 10 minutes of ingestion of the whiskey. There is usually dyspnea, cough, pounding of the heart, and tingling and numbness of the hands. In some cases there is also dizziness, visual blurring, and a pounding frontal headache. We classify as a critical reaction one in which the pulse rate rises and then falls with the systemic blood pressure, resulting in dire shock. Nausea and severe headache are considered to be signs of imminent shock. During the past 4 years in our use of disulfiram, we have taken precautions to minimize the severity of the reaction since our studies reveal no significantly more favorable subsequent clinical course following severe or critical reactions than after mild or moderate reactions. Even with our conservative doses of disulfiram and alcohol, severe reactions do rarely occur. There have been no reaction fatalities in our series.

Mortensen-Larsen¹ has suggested a means of predicting the reaction severity by evaluation of sensitivity to alcohol (by history of hyperactivity when drunk) and sensitivity to disulfiram (by pre-reaction side-effects of disulfiram). In our clinical experience the latter criterion appears to have predictive value. We have found that reactions can be successfully controlled by administration of epinephrine in small, frequent doses, oxygen, elevation of the foot of the bed, and intravenous fluids. If the response is not satisfactory within 10 to 15 minutes, 1-Norepinephrine is added to the intravenous fluid. We have used intravenous iron and ascorbic acid with but indifferent success in terminating reactions. Galvanic leg muscle stimulation has been found useful in controlling shock but is no longer used.

In a few cases we have omitted the planned reaction and have permitted the patient simply to observe the reaction of a fellow patient. It is our feeling that if reactions are given, the hospital with trained personnel for routine procedure is the correct setting. The reaction is not a conditioning stimulus, nor is disulfiram therapy an "aversion treatment." The collection and analysis of our data have not advanced far enough to permit us to state whether disulfiram patients who do not experience a planned reaction test have a poorer or better rehabilitation record than those who do.

AGE DISTRIBUTION OF PATIENTS

The disulfiram group of 1,020 patients differs in several particulars from the 484 control patients. As Table I shows, the disulfiram patients constitute a

TABLE I
AGE DISTRIBUTION

AGE GROUPS	DISULFIRAM PATIENTS	CONTROL PATIENTS
19	1	0
20-24	15	1
25-29	98	25
30-34	179	60
35-39	278	83
40-44	219	92
45-49	145	88
50-54	63	60
55-59	21	45
60-64	0	20
65-69	1	8
70-74	0	1
75 and over	0	1

Age distribution of disulfiram and control patients

younger group than the controls. The peak for the disulfiram patients is in the 35 to 39 year age category while that for the controls is in the 40 to 44 year old group. This shift to the left of the disulfiram population distribution curve is believed to result from our selection device in which younger, healthier, more courageous, and more highly motivated patients accept a somewhat fearful therapeutic adjunct that is rejected by or denied to older patients with more profound deterioration.

PROBLEMS INVOLVED IN EVALUATION OF THERAPY

Several problems are presented in an attempt to evaluate the results of therapy of alcoholics. Our series is limited by the fact that no case has been continued from a period earlier than June, 1949. The last patient included in the series was admitted on October 21, 1953. Also we are dealing with a segment of the alcoholic population selected on the basis of willingness to accept treatment voluntarily. Selection of criteria by which therapeutic progress may be judged offers difficulties. Some of the most realistic criteria elude objective, mathematical handling and are thus of limited value. In the present evaluation we have used abstinence as a criterion. This criterion has several defects and perhaps overbalances the emphasis upon drinking in the patient's total problem.

CLASSIFICATION OF RESULTS

The following is a classification of treatment results:

Class I comprises patients reporting total abstinence since the onset of treatment.

Class II includes patients who have maintained abstinence with but a single relapse.

Class III includes those patients who have not maintained abstinence but who have shown improvement as measured by wider spacing of drinking episodes, better work record, and happier adjustment in home and community.

Class IV consists of patients in whom no improvement can be seen.

Class VI is a rather small class containing those patients, placed in the unimproved class in earlier appraisals, who have been continuously abstinent over six months.

Class NT comprises patients who early discontinued treatment through self discharge or other means.

Class NC contains those patients whose status cannot be evaluated since contact with them has been lost. It may be reasonably assumed that Classes IV, NT, and NC represent, for the most part, therapeutic failures.

TABLE II

CLASS	DISULFIRAM PATIENTS		CONTROL PATIENTS	
	NO. PATIENTS	PER CENT	NO. PATIENTS	PER CENT
I	279	27.4	111	23.0
II	201	19.7	46	9.5
III	274	27.0	94	19.4
IV	148	14.4	67	13.8
VI	26	2.5	15	3.1
NT	10	1.0	81	16.7
NC	82	8.0	70	14.5
	1020	100.0	484	100.0

Comparison of therapeutic results in 1,020 disulfiram patients and 484 control patients. Definitions of the classes in the left column are given in the text.

COMPARISON OF CLINICAL COURSE

Table II gives a comparison between the clinical course of the 1,020 disulfiram cases and the 484 controls. We see that 27.4 per cent of the former have maintained abstinence as compared with 23.0 per cent of controls. Adding Group I, II, III, and VI, we find that 76.5 per cent of the disulfiram patients have benefited by treatment while 55.0 per cent of the controls are classified as improved. The follow-up record is better in the disulfiram than in the control group. Of the former, only 1.0 per cent broke treatment early and 8 per cent cannot be traced. Of the controls, 16.7 per cent discontinued treatment early and in an additional 14.5 per cent contact has been lost. Statistical analysis reveals *p* values of less than 0.01 in *t*-tests of significance of difference between Classes II, III, NT and NC of the disulfiram versus control groups and *p* of 0.10 to 0.05 for Class I. For Classes IV and VI, the *p* values are greater than 0.05. Thus, the differences between the disulfiram and control abstinent groups are questionably significant; the differences for II, III, NT and NC are highly significant; while the differences for IV and VI are not considered significant. A *t*-test of significance of the difference between the scores of 76.5 per cent improved in the disulfiram group and 55.0 per cent in the controls gives a *t* value of 8.3 and *p* of less than 0.01. Disulfiram patients, therefore, do significantly better than the controls.

MALES VS. FEMALES

Table III shows that in the disulfiram group in our series, male patients do significantly better than females. Of the male disulfiram patients, 77.4 per cent are improved; while 67.3 per cent of the disulfiram women show improvement. ($t=2.1$; p less than 0.05). Table IV gives a comparison of the performance of the control men and control women. In the control group, 55.8 per cent of the men and 49.3 per cent of the women are classified as benefited. A test of significance gives $t=1.0$; p greater 0.05. Thus, the difference between the clinical progress of the control males and control females is not significant. A test of significance of the difference between the improvement scores of disulfiram males versus control males gives $t=7.7$ and p less than 0.01, a highly significant difference. The difference between the improvement scores of disulfiram women versus control women is also significant. ($t=2.3$, p less than 0.05).

TABLE III
DISULFIRAM PATIENTS

CLASS	MALES		FEMALES	
	NO. PATIENTS	PER CENT	NO. PATIENTS	PER CENT
I	257	27.9	22	22.4
II	188	20.4	13	13.3
III	247	26.8	27	27.6
IV	127	13.8	21	21.4
VI	22	2.4	4	4.1
NT	5	0.5	5	5.1
NC	76	8.2	6	6.1
	922	100.0	98	100.0

Comparison of therapeutic results in 922 male disulfiram patients and 98 female disulfiram patients.

TABLE IV
CONTROL PATIENTS

CLASS	MALES		FEMALES	
	NO. PATIENTS	PER CENT	NO. PATIENTS	PER CENT
I	100	23.7	11	17.5
II	43	10.2	3	4.8
III	79	18.8	15	23.8
IV	51	12.1	16	25.4
VI	13	3.1	2	3.2
NT	69	16.4	12	19.0
NC	66	15.7	4	6.3
	421	100.0	63	100.0

Comparison of therapeutic results in 421 male control patients and 63 female control patients.

AGE GROUPS

Our earlier report, published in 1953, on patients accepted through October, 1951 showed consistently poorer results for patients under 30 in both the disulfiram and control groups.² Our present more complete, longer-term studies now indicate that the under 30's have nearly but not quite as good a record as the total groups. In the disulfiram group, 71.1 per cent of a total of 114 patients under 30 were benefited. In the control groups, 11 out of 26 under 30's showed improvement. The disulfiram age groups below 40 are somewhat poorer than the total group in percentage improved; the disulfiram age groups over 40 are somewhat better. Of the age categories where significant percentages may be derived, it appears that the disulfiram group between the ages of 40 and 44 made the best score. (79.4 per cent improved out of 219 cases). Among the control patients the percentages of improved in each age category do not indicate any clear trend. The 40-44 age group has the best score with 64.1 per cent improved out of 92 patients but they are only slightly better than the 30-34's and the 50-54's. At the extremes of both the disulfiram and control age-group curves, the numbers of cases are too small to provide significant data.

COMPARISON OF RESULTS

Our studies reveal that under the conditions of our therapeutic program, the disulfiram group as a whole does better than the control group. This is particularly evident in the significantly higher proportion in the disulfiram group of those in Classes II, III, and VI, that is, those who have had one relapse or more but who seem to have established a stable alcohol-free pattern finally. Inspection of the statistics at once exposes the striking fact that the disulfiram group has a much better record of follow-up and contact with the clinics than do the controls. A major function of disulfiram may, therefore, be to differentiate more highly from less highly motivated patients, to select those who will continue treatment more faithfully, and to provide additional incentive for continuation of treatment. To investigate this point statistically, we have withdrawn the NT and NC patients from both the disulfiram and control groups and studied only those who actually followed up and kept in contact. (Class I, II, III, IV, and VI). Comparing 928 such disulfiram cases with 333 such controls, we find that 84.1 per cent of the disulfiram group may be listed as improved

while 79.8 per cent of the controls are so listed. Analyzing the significance of this difference, we derive $t=1.7$ and p between 0.10-0.05 which is not considered clearly significant. In our Service, therefore, there is not a decidedly significant difference between the disulfiram and control groups if we eliminate those who dropped out of treatment early or broke contact.

A further analysis remains. In our earlier studies we found a difference in performance between those controls who were denied disulfiram and those who rejected it, the former having a much better subsequent record than the latter. We have not yet derived similar statistics in the present study but it is likely that the conclusions will be the same.

It is not proposed in the present report to discuss the various meanings of disulfiram for patients. Our

clinical judgment suggests that for individual patients, disulfiram has meaning that is contributory to a favorable course. It is concluded that disulfiram is a useful adjunct in a comprehensive plan of therapy of patients amenable to voluntary treatment.

We desire to express our grateful thanks to Ayerst Laboratories for supplying all of "Antabuse" used in this investigation.

Grateful thanks are expressed to Dr. Murray G. Mitts, Research Assistant, Department of Neurological Science, Medical College of Virginia, who carried out the statistical analyses reported in this paper.

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THE MANAGEMENT OF ACUTE HAND INJURIES

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INTRODUCTION

Being normally accustomed to the possession of two five-fingered hands which function properly, one may forget the disability imposed by sensory or motor deficit in even one of the components. Everyone is a "manual worker" to some degree. Trauma to the hands, both industrial and domestic, constitutes a large per cent of the injuries seen in present day practice. Based upon the work of Sterling Bunnell and others, and aided by experience in World War II, a large body of knowledge has developed concerning the management of disorders of the hand. The scope of modern reconstructive surgery is broad in its ability to assist in rehabilitation of the individual with an upper extremity crippled by trauma. Because most acute hand injuries are not managed by physicians possessing this special knowledge, it is important that some of the general prin-

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SUMMARY

The basic considerations and precautions cited herein are presented as a few of the important factors in the successful management of the injured hand. Reference is made to several errors which are not infrequently made in the care of patients who have sustained trauma to the upper extremity.

ciples concerned be more widely disseminated. It is for such a reason that this article is written. It is hoped that misconceptions can be dispelled, misconceptions which are the cause of common errors in treatment.

GENERAL CONSIDERATIONS

A fact which should be self evident, but which unfortunately is not always so, is the importance of keeping to a minimum the time lapse between injury and definitive treatment. The outlook for primary healing of wounds is best when debridement and closure are carried out early. Evaluation of the severely injured hand at the accident room level should be brief, consisting of testing of nerve, tendon, and circulatory function, but exploration of major hand wounds is better deferred until the more ideal conditions of the operating room are reached. Treatment in the emergency room may be limited to such measures as initial splinting in preparation for radiological evaluation, relief of pain, arrest of hemorrhage, prevention of shock, and tetanus prophylaxis.

In the operative management of a major hand injury adequate anesthesia is mandatory. Local anesthetic agents, besides causing pain during their infiltration, spread tissue and can compromise circulation. In the digits the tension of infiltration can produce ischemia, and it is particularly hazardous when adrenalin is used to prolong the effect of the anesthetic. General anesthesia is indicated when any of the important structures are damaged, or when exploration is necessary. Complete relaxation of the tissues involved is mandatory. Regional nerve blocks, as of the brachial plexus, also have a definite place in this type of surgery.

It is an error to attempt repair of major hand injuries under conditions less exacting than those of a hospital operating room. Plastic and neurosurgical techniques are involved, and these are not adaptable to other situations. The importance is stressed of adequate lighting, intelligent assistance, and suitable instruments.

The entire arm may ultimately be involved in surgery of the hand, consequently the operative field should include most of the extremity. It is a common error to prepare and drape the hand and wrist, only later to find that a more proximal incision is necessary to locate the proximal end of a tendon. It also may become apparent only during the operation that a segment of a nerve has been

lost, and that the more proximal part will have to be mobilized to span the gap. This may require dissection well up the arm.

The pneumatic tourniquet is of such value in the delicate work of hand surgery in providing a bloodless field, that to operate without it may be unwise. It should be put in place prior to the preparation and draping, and then inflated when the field has been prepared and the venous blood expressed with a sterile Esmark bandage. The elastic bandage should not be wrapped flush with the pneumatic cuff. Rather, two to three centimeters of skin should be left between the two. Wrapped all the way, some cuff pressure is lost when the elastic bandage is removed, and bleeding may no longer be prevented. Because of the time limit imposed by the ischemia so produced, the application of the tourniquet should be the last step prior to initiating the surgery. The tourniquet should be released within two hours. It is also well to remember to release the tourniquet prior to closing the wound. This not only will indicate significant bleeders, but also may indicate tissue that is poorly vascularized and liable to remain ischemic.

Many principles which should be obvious are easily forgotten. Regardless of the nature of the wound, living tissue must be treated gently. Irrigating, blotting, and sharp dissections have long since supplanted wiping and scraping. Caustic antiseptics are to be condemned. Buried sutures and ligatures should be used as little as possible, and sutures which are tied tightly enough to cause blanching should be removed. Use of the finest suture material is advisable.

The prevention of tetanus is an important consideration. The nature of the wound will, in a large part, determine the potential for this infection. Nevertheless, prophylactic tetanus antitoxin is indicated, unless the person is known to have been immunized or has had a booster toxoid shot within the past three years, in which case a repeat booster is sufficient. This latter point speaks strongly for the preventive medicine program of antitetanus immunization and maintenance.

INCISIONS AND THE INTEGUMENT

If there is a suspicion of a retained foreign body, the wound should not be left without adequate exploration. Reaction around a foreign body and subsequent infection can be severely crippling.

Extensions of a wound to provide exposure and

incisions for exploration must follow established principles, or may themselves compromise the subsequent function. Longitudinal volar or dorsal cuts will cripple a finger by subsequent scarring, whereas a midlateral incision will not encroach upon the joint creases and so will permit continued free motion at the metacarpophalangeal and interphalangeal joints. Longitudinal incisions perpendicular to the wrist flexion creases will subsequently limit extension, and indirectly infringe upon hand function. The motor branches of the median and ulnar nerves in the palm must always be kept in mind.

In digits so severely traumatized as to be beyond reconstruction, those parts which are still viable may serve a useful purpose in subsequent surgery. Thus a "fillet" of the remaining viable skin and subcutaneous tissue of a finger may well be the tissues needed to serve for coverage of a defect in the palm or dorsum. Certainly with the thumb every effort should be made to save all parts possible for later reconstructive maneuvers.

SKELETAL INJURIES

Soft tissue contusions, in general, will warrant radiological investigation if the possibility of skeletal trauma is felt to exist. In the management of fractures of the metacarpals and phalanges, skeletal traction may often be used to advantage. However, it is a common error to immobilize these parts in divergent extension using such devices as the banjo splint. Methods of traction which fix the metacarpophalangeal joints in extension are to be avoided. In this position the collateral ligaments of these joints are relaxed, and are thereby subject to shortening during the period of immobilization. The consequent limitation of flexion interferes with the important functions of grasp and pinch. This same principle has led to the condemnation of the tongue blade splint, or of any method which fixes the metacarpophalangeal joint in extension.

Another common fracture, difficult to handle, is that of the distal end of the shaft of the fifth metacarpal. Often to reduce this fracture the little finger is doubled in plaster with appropriate forces applied for reduction of the fracture, and as a result the skin at the pressure points undergoes necrosis. This adds further problems to a situation which initially could well have been treated by intramedullary fixation with Kirschner wires. The results using the latter method are excellent.



FIGURE 1

Right hand of an industrial worker whose injury occurred when the extremity was caught in the blower of a heavy industrial machine. This is a moderately severe compound injury with avulsion of the soft tissue of the dorsum of the hand, fractures of the proximal phalanges of digits 2, 3, and 4, and avulsion of the soft tissue of the middle and distal phalanges of the 3rd digit. The 3rd digit fracture is compounded.

TENDON INJURIES

Tendon severance is an indication for prompt attention to the wound. Early cleaning and debridement is important, and skilled management of the divided tendon is of equal concern. The first attempt at tendon repair is crucial. Second attempts at subsequent dates may not be as satisfactory. In the proximal palm and in the forearm where the tendon lies free amidst the adjacent soft tissue, adhesions following injury are so diffuse that it is advisable to try to achieve a primary repair. Here again, however, the degree of contamination of a wound is a limiting factor.

Both flexor profundus and sublimus tendons can be sutured when they are severed proximal to the distal palmar crease. In the palm interposing the lumbrical muscle tissue between the suture sites will help maintain separate action. In the wrist multiple tendon divisions can be repaired primarily with good results.

The volar flexor sheath of the fingers extends from the distal palmar crease to the middle digital crease. The suture of a tendon in this area is almost surely doomed to adhesion within the canal and poor results. Management of tendons in this area requires every refinement of technique. In general, best results are obtained by tendon grafts designed

to bridge this area. For this reason it is usually advisable to strive for primary closure of the wound, and to delay attempt at tendon repair in this region. A common mistake lies in attempting to approximate the cut ends of both profundus and sublimis tendons. The sublimis, if cut, should be retracted from the flexor sheath through a small transverse incision in the palm proximal to the distal palmar crease, and amputated there. It should be remembered, however, that this cannot be done without first dividing the encircling arms of the sublimis tendon as they round the profundus tendon before inserting on the middle phalanx. This oversight can greatly complicate the situation when an attempt is made to retract the cut end. Removing the sublimis tendon will allow more room for swelling of the injured profundus with less risk of adhesions within the canal. Suturing the sublimis would simply result in adhesion to the adjacent suture line of the profundus or in crowding within the flexor canal, and would ultimately restrict the function of the latter tendon.



FIGURE 2

Buzz saw injury, right hand. There is amputation of digit 4, severe soft tissue avulsion on the ulnar side of digit 3, and a deep wound of the thenar eminence with severance of the flexor pollicis longus.

In suturing tendons every effort should be made to minimize the amount of exposed suture material on the surface. It is better to rely on splinting to maintain the approximation. The tendon should be kept under control of splint for three weeks, then gradually mobilized with care to avoid excessive tension. The technique of the removable stainless-steel, pull-out wire is another advancement in the reconstruction of disrupted tendons.

NERVE INJURIES

The primary suture of a divided nerve can give

remarkably good results, but only when a clean, fresh wound exists. A good repair requires the use of very fine silk, seating the sutures only in the perineurium and obtaining correct axial alignment. If such conditions cannot be met it is better to leave the severed ends for a secondary approximation at a later date. When secondary repair is contemplated, at the time of the initial debridement it is sometimes helpful to approximate the cut ends of a nerve with a single suture to prevent retraction.

In explosive wounds nerve damage is usually more extensive than is apparent, and a successful primary repair may be impossible. A delay of four to five months will clarify much. In instituting such a delay, however, the denervated muscle groups should be splinted in the position of function to prevent contractures, and the anesthetic parts should be protected. Passive physiotherapy is too often forgotten and the muscles become fibrotic and stretched by the action of the unopposed antagonists before the nerve can be repaired and the regeneration can occur. This "long-term" phase of the management of hand injuries is often neglected, and the consequences can nullify all other efforts, no matter how good.

VASCULAR INJURIES

The preservation of a single neurovascular pedicle can save a digit which hangs by one strand of tissue. Frequently such a finger is needlessly amputated because of the difficulty of clinical assessment of viability in such instances.

The interruption of a large vessel in the arm can be repaired in many instances. When ligation of such a vessel is liable to result in subsequent amputation, every effort should be made to re-establish continuity. The results of reparative vascular surgery have been encouraging, and some extremities with major vessel injuries can be saved.

SECONDARY CLOSURE

Some injuries are better closed secondarily. The amount of nonviable tissue is difficult to ascertain and infection is frequent in power saw injuries. Gun shot wounds and close-range rifle wounds are commonly accompanied by considerable tissue maceration. Crushing, dirt-ground wounds must likewise not be closed primarily, whether seen within six hours or not. These are wounds which are best treated with large doses of antibiotics and delayed primary or secondary closure. Animal and human bites which have had an attempted primary closure

will usually present as severely infected wounds with systemic manifestations.

Exuberant granulations can be controlled with bulky pressure dressings, but secondary closures should not be delayed too long. At the end of one week the granulations should be ideal for trimming and for accepting grafts or for closure, provided they are not grossly infected. Delay much beyond this permits scar formation within the granulations and consequent poor nutrition for the grafts.

In treating a wound by secondary closure it must be kept in mind that vulnerable structures such as tendons, nerves, joints, and bones must be covered. These tissues will not support a free skin graft, and must be covered by pedicle flap, either from adjacent parts, or from a more distant site.

MISCELLANEOUS

An ideal situation for a primary pedicle flap is avulsion of a finger tip. Often though, such a wound is allowed to go on to pernicious granulation and a painful, protracted course. Sensory function in a pedicle graft is usually serviceable, and frequently is remarkable. In the aged, however, the immobilization imposed by pedicle grafting may not justify its use. In such instances a skin graft to the area accomplishes closure, and is functionally adequate. This latter technique is also a useful method of "dressing" a chronically infected, open wound in preparation for subsequent reconstruction.

Injuries of the forearm and particularly those about the elbow should be checked within twenty-four hours, and daily for two or three days there-

after if there is any sign of swelling. Ischemic contractures of a forearm and hand are a disheartening outcome, the avoidance of which demands early recognition of the potentiality. All encircling bandages should be divided longitudinally within twenty-four hours. Dressings next to the wound should not be encircling.

Good surgical care of a traumatized hand does not end with a well executed operation. In the immediate postoperative period the importance of adequate immobilization and elevation are to be remembered. The advisability of the use of antibiotics will be determined by the particular circumstances. To a large degree the eventual success, as measured by approach to normalcy of function, will be determined by the judgment and skill with which motion is begun. The intelligent use of the measures of physical medicine, physiotherapy and occupational therapy can contribute greatly to the rehabilitation of the individual who has had a serious hand injury.

The timing of any secondary reparative procedure, such as the placement of tendon grafts, will be determined largely by the nature of the healing process in the initial wound. Following a clean wound which has healed per primum, reconstructive measures can be considered after the lapse of only a few weeks, whereas the occurrence of a wound infection will necessitate much longer delays.

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DIGITALIS INTOXICATION

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SUMMARY

The case presented here is that of digitalis intoxication which occurred in an elderly woman who was on a maintenance dose of $1\frac{1}{2}$ grains of digitalis whole leaf for a period of months. Her only symptoms were shortness of breath of three days' duration and some orthopnoea. Physical examination revealed what seemed to be atrial fibrillation. However, electrocardiograms showed a severe type of arrhythmia consistent with a diagnosis of digitalis intoxication.

DIGITALIS is a wonderful drug for the treatment of patients with congestive heart failure. It is also very useful for treating various types of arrhythmia, such as atrial flutter, atrial fibrillation and paroxysmal atrial tachycardia.

However, it cannot be used without a clear recognition of its potential disadvantages. These occur because the margin between the therapeutic and toxic dose is required to achieve a therapeutic effect. Digitoxin,⁴ digoxin,⁵ lantoside C and digitalis leaf all fall into such a category. When ventricular extrasystoles are produced in animals by the use of digitalis, from 50 to 80 per cent of the minimal lethal dose has been given.^{6,7}

Digitalis intoxication of late has been increasing.³ This is thought by some to be due to the increased use of digitalis glycosides instead of digitalis whole leaf. Marriott³ states that with many physicians digitoxin has become a habit. "When a digitalis preparation is indicated, digitoxin is automatically prescribed, especially by the group of younger physicians who have received their training during the 'digitoxin era'." He believes that the increase in the incidence of digitalis intoxication is due to the routine use of this drug without due consideration being given to its power for prolonged action and its ability to cause intoxication without giving the usual warning gastrointestinal symptoms. Lown and Levine,¹ on the other hand, believe that the occurrence of toxicity bears no relation to the digitalis compound employed, but is conditioned by the extent of failure, the underlying etiology of failure, the cardiac reserve, the electrolyte balance, the concurrent use of other drugs and numerous other factors. They point out that anorexia, nausea, and vomiting are among the earliest and most common subjective manifestations of digitalis overdosage. These symptoms occur whether the drug is administered orally or intravenously.⁸ Emetic movements are not prevented by extirpation of the gastrointestinal tract or by extensive afferent denervation of the visceral structures. The vomiting is thus central rather than peripheral in origin. Advanced intoxication as evidenced by objective data sometimes occurs

in the absence of all subjective indications of overdosage.

Every form of arrhythmia and conduction disturbance has been attributed to digitalis. Three cases of paroxysmal ventricular tachycardia, three of idioventricular rhythm, and one of interference dissociation were reported by Levine⁹ as due to digitoxin. Master¹⁰ reported nine cases of digitalis intoxication due to digitoxin. In this series were cases of sinus, nodal, and ventricular tachycardia, auricular fibrillation and complete heart block. Batterman and Gutner¹¹ point out that digitalis poisoning may cause congestive failure or make more severe a congestive failure that is already present. Lown and Levine state that in their experience paroxysmal atrial tachycardia with block is a common, serious and specific clinical entity that usually results from digitalis intoxication.²

In man except for gastrointestinal symptoms the most common indication of digitalis overdosage is ventricular extra-systoles. If digitalis is continued, the ectopic beats may assume a fixed pattern of digitalis overdosage, such as coupled rhythm.

Digitalis in overdosage may further damage an already impaired heart. The worst complication¹ from digitalis poisoning is ventricular fibrillation. Digitalis bigeminy,¹² an indication of overdosage of digitalis, may be fleeting or last as long as 34 days.

Its persistence may be the result of both the digitalis intoxication and the severity of the heart disease already present before digitalis was given.

CASE REPORT

Mrs. L. E., white, age 81, admitted to the Medical Service of the Manchester Memorial Hospital on May 17, 1954. On the day of admission the patient's chief complaint was shortness of breath of three days' duration, which had progressed so that on the night before admission she was unable to sleep because of orthopnoea. Her appetite had been poor for the last few months.

Physical examination revealed a well developed but poorly nourished elderly white woman lying in bed complaining of difficulty in breathing. The blood pressure was 220/120. The heart sounds were of fair quality, the rate was rapid and the rhythm was grossly irregular. The heart was enlarged. There were moist rales in both lung bases, more pronounced on the right. A diagnosis of hypertensive cardiovascular disease with congestive heart failure and atrial fibrillation was made.

The patient stated that she was taking one digitalis pill each day during the past six months and this was confirmed by her family physician. On the basis of the information received, the intern thought that the amount of digitalis taken was probably inadequate and he ordered digitalis grains $1\frac{1}{2}$ twice daily. A chest film taken on May 18 showed

gross cardiac enlargement with evidence of pulmonary congestive changes.

An electrocardiogram on May 18 revealed runs of ventricular ectopic beats. Furthermore atrial beats showed a shifting pacemaker. Because of these findings it was concluded that the patient was suffering from digitalis intoxication. On May 19 the digitalis was discontinued. The patient had received grains $1\frac{1}{2}$ of digitalis at 8:00 P. M. on May 17, grains $1\frac{1}{2}$ at 8:00 A. M. and 8:00 P. M. on May 18, and grains $1\frac{1}{2}$ at 8:00 A. M. on May 19. On May 21 the electrocardiogram showed increased ventricular irritability with multifocal ectopic beats. Twenty-four hours after pronestyl was administered there were ventricular and nodal ectopic beats. The patient was kept on pronestyl.

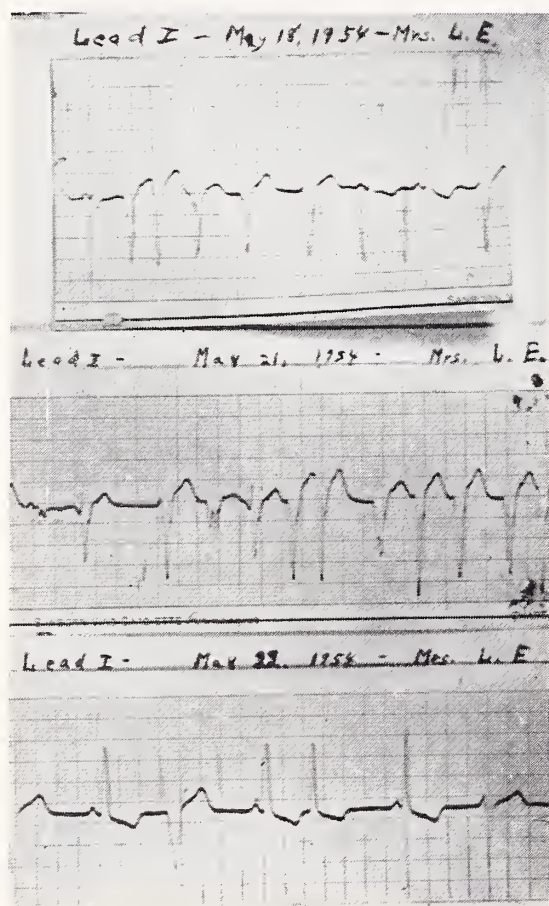


FIGURE 1

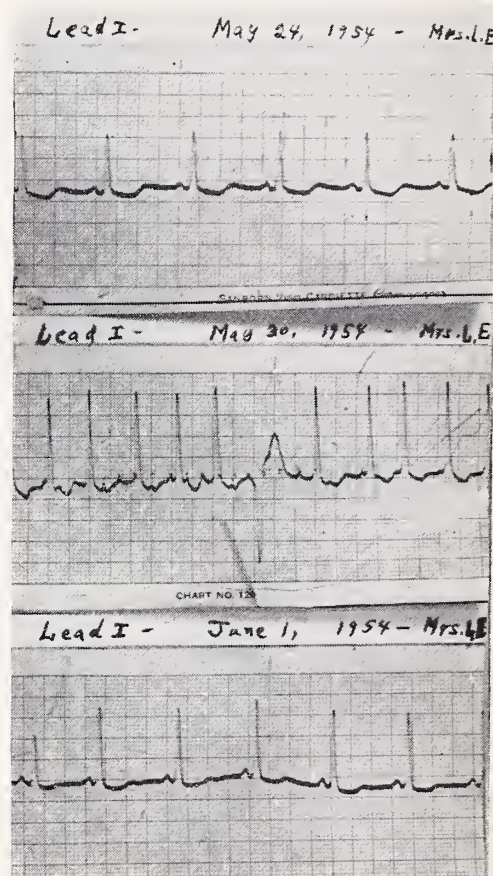


FIGURE 2

On May 24 normal sinus rhythm returned, but the ventricular complexes still exhibited scooping of the S T segments. This would seem to indicate that digitalis effects were still present although S T-T was prolonged and QTc was over 600. The pronestyl was continued through May 25, 26, 27 but was stopped on the morning of May 28. Two days after pronestyl was discontinued the heart had again become rapid and irregular. The electrocardiogram of May 30 showed atrial fibrillation. One ventricular ectopic beat was present. Pronestyl was resumed and on June 1 normal sinus rhythm returned. There was still some slight scooping of the S T segment which would indicate that some digitalis effect was still present.

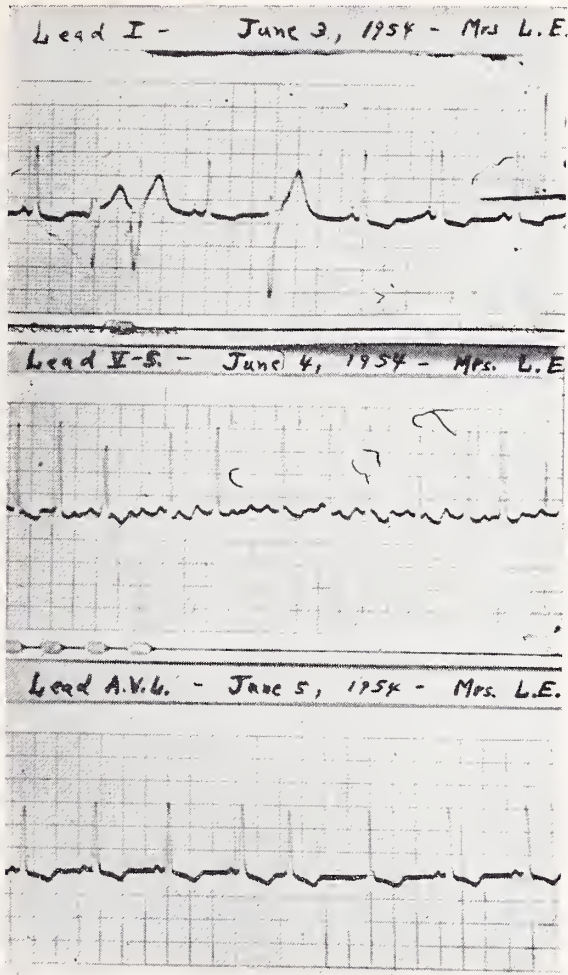


FIGURE 3

Upon discontinuance of pronestyl, ventricular ectopic beats recurred on June 3. On June 4 the patient developed a rapid irregular heart and the electrocardiogram revealed atrial fibrillation. Pronestyl was resumed and on June 5 normal sinus rhythm had been established. There was one premature auricular beat present. S T was depressed and T inverted. On pronestyl the patient continued to improve and was discharged from the hospital on June 9. On June 10 her heart was predominantly regular with an occasional ectopic beat. When questioned, she stated that she had not taken any pronestyl since her discharge from the hospital. On June 12 her condition remained unchanged. She still complained of weakness.

On June 14 an electrocardiogram revealed both auricular and ventricular ectopic beats. The S T segment was slightly depressed and the T inverted. Accordingly pronestyl was resumed and on June 19 the heart rate and rhythm were normal. Pronestyl was again discontinued and on June 25 normal sinus rhythm had been established. The S T-T complex remained unchanged. The patient was last seen in the office on June 29. She stated that she had taken no medication and that she felt strong enough to go for an automobile ride. Physical examination revealed a heart rate of 80 with an occasional irregularity.

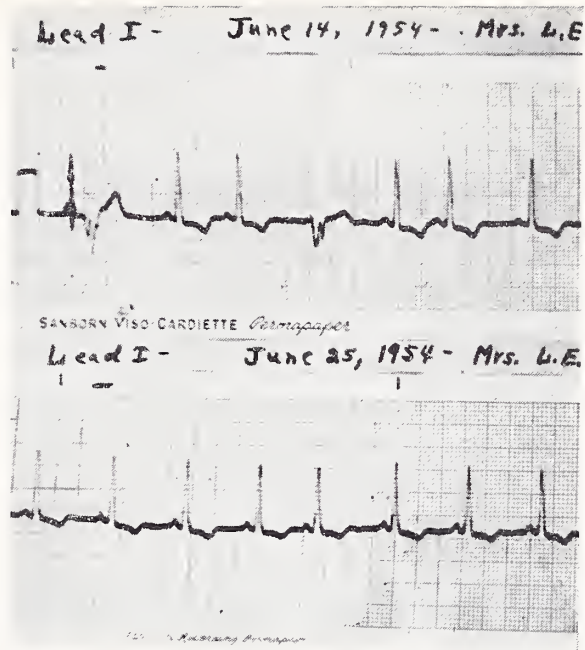


FIGURE 4

DISCUSSION

An unusual case of digitalis intoxication has been presented. This patient was receiving what was deemed a safe maintenance dose of digitalis whole leaf, but in spite of this she developed digitalis intoxication. It is rather unusual for patients to develop intoxication of this severity on a daily maintenance dose of one and a half grains of digitalis whole leaf, but it can be postulated that this patient was not excreting this amount each day and was therefore accumulating in her system over a long period of time a sufficient amount of the drug to cause severe intoxication. It has been pointed out that in the past few years the number of cases of digitalis intoxication has been increasing. It has been thought³ that this recent increase in the cases of digitalis intoxication has been due to the increased use of digitalis glycosides. On the other hand, Lown and Levine¹ have expressed the belief that digitalis intoxication occurs when an overdosage of any type of digitalis is given. The case cited seems to support this belief.

This case is also unusual in that there were no other symptoms of digitalis intoxication, such as nausea and vomiting. However, there was some loss of appetite. The diagnosis of digitalis intoxication was made on the basis of electrocardiograms, which showed a serious type of arrhythmia, thought to be

due to digitalis intoxication. Subsequent events proved this to be true.

CONCLUSION

Digitalis intoxication may occur in any patient treated with any type of digitalis medication. It may be due in part to the increased use of digitalis glycosides, but intoxication may occur even with the use of digitalis whole leaf preparations. In most such instances there are warning signs such as nausea and vomiting before severe arrhythmia occurs. However, in the case presented in this paper the only sign of digitalis intoxication was the arrhythmia. This possibility should be kept in mind so as not to miss cases of digitalis intoxication in which premonitory symptoms may be totally lacking.

When cardiac arrhythmias occur in patients on digitalis therapy, electrocardiograms should be taken, especially in those who had no arrhythmia previous to this therapy. Many times this procedure will help to establish the diagnosis. It is also apparent from this case that where an arrhythmia is due to digitalis intoxication, pronestyl is a very efficient corrective drug.

I wish to express my thanks and appreciation to Dr. Louis Nahum for reviewing the electrocardiograms with me.

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CONGENITAL CYSTS, SINUSES, AND FISTULAE OF THE NECK

Surgical Treatment

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KNOWLEDGE of the congenital lesions of the cervical region is important to the surgeon both in the differential diagnosis and in the treatment of masses or sinus openings in this area. Failure to recognize the nature of these anomalies, and thus failure to carry out proper surgical therapeutic measures may result in disappointing recurrences, infection, discharge, and disfigurement, as well as increased morbidity to the patient.

The developmental anomalies of the cervical region can be divided into two main categories depending on location and system of origin. Thus, cysts and sinuses of the thyroglossal tract are usually found in the anterior midline of the neck, while anomalies arising from the embryologic pharyngeal

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SUMMARY

Congenital lesions of the neck are important and present interesting developmental anomalies often requiring surgical removal. Knowledge of the embryologic origin, and thus of the anatomical relationships of the various types of lesions is necessary for proper treatment. Inadequate surgery will lead in most cases to recurring infection with drainage and scarring, and to increased patient morbidity. The salient points of diagnosis and treatment of the two main groups of cervical anomaly are presented.

pouch and cervical sinus present laterally, along the anterior border of the sternomastoid muscle.

CYSTS AND SINUSES OF THYROGLOSSAL TRACT ORIGIN

Embryology: The anlage of the thyroid gland appears in the 2.0 to 2.5 mm. embryo as a midline structure, projecting downward from the pharynx between the first and second branchial arches. This point of origin corresponds to the foramen cecum in adult life. The midline thyroid anlage then descends in the course of development to its position in the anterior neck. Normally, any connection between the cervical thyroid and its point of origin at the base of the tongue is obliterated and disappears. At times, however, remnants of the strand of tissue connecting these points may remain, along with portions of the epithelial lining of the mouth cavity, to persist as definite structures, and form cysts, sinuses and fistulae in later life.^{13,14,22,23}

The relation of these embryologic remnants to the hyoid bone has provoked much discussion in the past. The hyoid bone, derived mainly from the second arch, grows from behind forward, and divides the persistent thyroglossal tract into a suprahyoid and an infrahyoid portion. At this point the two structures become intimately associated, the tract appearing to pass anteriorly, posteriorly, or through the substance of the bone. The difficulty of determining this relationship at operation makes it necessary to remove a portion of the hyoid bone to assure complete removal of the tract.

Clinical Aspects: Lesions of the thyroglossal tract may present as cystic swellings or sinus openings in the anterior portion of the neck. The cystic lesions form the major group of the abnormalities, Clute and Cattell⁴ reporting 41 cysts, 18 sinuses and one fistula in 58 patients, Gross and Connerley⁹ reporting cysts in 85 per cent of lesions in children, and Stahl and Lyall²¹ reporting 55 cysts in 90 patients with thyroglossal tract anomalies.

Thyroglossal tract cysts may be found anywhere in the midline cervical structures from the base of the tongue down to the suprasternal notch. The masses vary considerably in size, averaging 3.0 cm., but may be as large as 10 cm. in diameter. They are usually smooth and well defined, and do not show fixation to the skin unless infection has been present or surgical drainage performed. Some of the smaller cysts may be quite mobile, although some degree of fixation to the hyoid bone is usual, and often a cordlike structure may be palpated in this area. Move-

ment on deglutition may be elicited. Tenderness is not common unless infection is present. In rare instances complete internal tracts may exist, usually secondary to breakthrough of infection into the pharynx, and in such a situation it may be possible to express fluid into the pharynx by pressure over the cyst. This finding, however, is so rare as to limit its usefulness in diagnosis, being found in one case in Clute and Cattell's series of 58 patients,⁴ and in one case in 90 patients reported by Stahl and Lyall.²¹

Sinuses of the thyroglossal tract have their openings in the anterior neck from the suprasternal notch to the region of the hyoid bone. These openings are usually considered to be secondary to spontaneous rupture of an infected cyst or to surgical drainage of inflammation or abscess. Most of the openings are found in the midline, although the sinus may be some distance to one side, due to lateral pointing of the underlying infection. The cutaneous openings are usually 1 to 3 mm. in diameter, and show moderate to extreme inflammatory changes in the surrounding skin. Drops of mucoid, clear, or purulent fluid may be expressed from this opening, and it is often possible, by careful palpation, to outline a tract running from the skin lesion upward to the hyoid bone.

The average age of patients presenting with anomalies of thyroglossal tract origin has been determined to range from 24 to 30 years, with a large proportion of patients noting the presence of the lesion prior to the age of ten. Onset at later ages does not preclude the diagnosis, however, as Clute and Cattell⁴ have reported one case noting initial symptoms at the age of 71 years. They are found in approximately equal proportion in males and females.

Differential diagnosis: The diagnosis of lesions of the thyroglossal tract usually may be made on the finding of a midline cystic swelling or sinus, generally in the region of the hyoid bone, which may move with deglutition, and deep to which may be palpated a cordlike tract. Anomalies of the pharyngeal pouch and cervical sinus, as discussed below, are usually located laterally in the neck and should not be confused for this reason. Submental adenitis may usually be differentiated if infection in the teeth, lips, or chin is found. Suppurative lesions in the mediastinum may be the origin of sinus openings below the region of the thyroid, and chest x-ray should be done in these cases. Lipomata of the neck are uncommon and are usually lobulated dermoids

and sebaceous cysts can usually be differentiated by their superficial position and fixation to the skin, although the occasional dermoid encountered deep to the platysma may be indistinguishable. Discrete tuberculous adenitis may also be difficult or impossible to differentiate preoperatively.

Confusion with lesions of the thyroid gland may occasionally arise, and several cases diagnosed preoperatively as thyroid adenomas have proven at operation to be thyroglossal cysts. This in itself is of no great practical moment if proper therapy is carried out, however, the rare case of thyroid gland ectopia presents a serious problem in treatment. In rare cases the entire functioning thyroid tissue of an individual is located high in the neck, along the course of thyroid descent, or may be found undescended at the base of the tongue. Removal of this tissue under the impression that it is a thyroglossal cyst would lead to total hypothyroidism. Gross^{8,9} cited one such case, and others are to be found in the literature. As a safety measure Gross recommends the opening of any cyst in this area found to contain solid material, and if thyroid tissue is found, the exploration of the neck to determine the presence of a normal thyroid gland.

Treatment: Sistrunk¹⁹ in 1920, first advocated the routine removal of a portion of the hyoid bone in all cases of thyroglossal cyst or sinus. Schlange¹⁸ in 1893, and Durham⁵ in 1894, had advised removal of a portion of the hyoid in selected cases, but the concept of the utilization of this procedure in every case was promulgated by Sistrunk in his reviews of the results of treatment of such cases in 1920¹⁹ and 1928.²⁰ Less radical removal has led to a high rate of recurrence of the lesion, usually cured subsequently by the application of the radical operation.

The procedure advocated at present differs little from that described by Sistrunk in 1920. The patient is positioned as for thyroidectomy, supine, with the neck extended to expose the hyoid area. Endotracheal inhalation anesthesia has been the agent of choice in recent years. A transverse incision, 3 to 4 cm. in length, is made in the skin crease of the neck overlying the mass if the lesion is a cyst. If a sinus opening is present, or if there are scars of previous operative procedures, these are removed by a transverse elliptical incision. It has not been found necessary or advantageous to inject the tract with dye or marking fluid.

The incision is then deepened through subcutaneous fat and platysma muscle, isolating the cyst or

sinus from these tissues by sharp dissection. Slight traction is then made, facilitating the dissection of the deep fascia from the tract. At this point it is possible to divide in a vertical plane any deep tissue overlying the deeper layer of muscles, and so expose the oblique fibers of the mylohyoid in the upper aspect of the wound, and the vertical fibers of the sternohyoid in the lower aspect. The thyroglossal tract will then be seen to course upward to the hyoid bone, which lies at the junction of these two muscle groups.

Sharp dissection frees the upper and lower borders of the central 1.0 to 1.5 cm. of the hyoid bone from its muscular attachments. The hyoid may then be grasped with an Allis clamp just to one side of the midline and pulled forward. Division of the bone is made, using a scalpel or heavy scissors in younger children, and bone cutting forceps in older children and adults. The opposite side is then divided in similar manner. A core of muscular tissue is dissected from the surrounding muscles down to the thyro-hyoid membrane and the mucous membrane of the pharynx. This step is facilitated by having the anesthetist or assistant place a forefinger in the mouth and exert outward pressure over the region of the foramen cecum, thus bringing this tissue up from the depths of the wound. The thyrohyoid membrane may usually be identified by its smooth, grey-yellow appearance, and the muscular tissues are divided to this depth with the dissecting scissors to completely isolate the tract. At this point the tract may be cut across and removed.

Closure is effected by approximating the mylohyoid and strap muscles with several interrupted sutures. The severed ends of the hyoid bone need not be brought together by suture unless they fall together naturally. The platysma and subcutaneous tissues are then approximated with fine interrupted sutures and the skin closed by the method desired. Nonabsorbable suture material is used throughout. One small rubber tissue drain may be left down to the mylohyoid muscle if desired, to be removed in 24 hours.

Pathology: Cysts and sinuses of thyroglossal origin show mixed epithelial lining, composed of pseudostratified columnar cells, which may be ciliated, and squamous cells. This lining may be smooth, but often there are small irregularly branched side pockets extending for various distances into the surrounding tissue. Mucous glands are occasionally seen. Subepithelially there may be found varying

degrees of acute and chronic inflammatory infiltration. Thyroid tissue is seen on occasion. Sections of the central portion of the hyoid bone show an irregular or branching, epithelially-lined tract piercing the bone or periosteum. These areas are often undetectable grossly. Microscopic sections of the tissue above the hyoid often show epithelially-lined remnants not suspected by visualization or probing. These grossly undetectable rests of thyroglossal tract may form the basis for subsequent recurrence, and emphasize the necessity for complete removal of the tract area by the radical operation in all cases of thyroglossal tract anomaly.

LATERAL CERVICAL CYSTS, SINUSES, AND FISTULAE

Embryology: The development and maturation of the branchial complexes of the human embryo take place from the fifteenth day of gestation to approximately the middle of the second month. During this period many intricate and important relationships are evolved in the conversion of embryonic gill cleft structures to fetal organs adapted to air breathing. The branchial apparatus develops as five bars of mesoderm separated by grooves or clefts. These structures are covered externally by flat epithelium, and lined internally by columnar epithelium. Each arch contains a cartilage, and through each arch runs a blood vessel and a nerve. Rapid growth of the upper arches results in the formation of an ectodermal recess in the lateral wall of the neck known as the cervical sinus.^{10,11} Ventral and lateral growth of the pharyngeal pouches brings them in contact

with this sinus, with a dividing or limiting membrane being formed at the ventral extremity of each pouch. This membrane is composed of a layer of columnar entodermal cells from the pharyngeal pouch, and a layer of flat ectodermal cells from the cervical sinus. In the area of contact of the third pouch the thymus gland and the lower pair of parathyroids originate, while in the area of contact of the fourth pouch the upper pair of parathyroids develops.^{7,14,15,22,23} The adult derivatives of the various branchial structures may be found in Tables I, II, and III.

The exact origin of the lateral cervical anomalies has been a subject of discussion since von Ascherson first related them to the branchial apparatus in 1832.¹ Two theories have been advanced, that of origin from pharyngeal pouch and cervical sinus by breakthrough of the limiting membrane, and that of origin from the duct of the developing thymus gland, (pharyngo-thymic duct). Careful study of the available information seems to indicate that these lesions develop from persistence of the cervical sinus structure with connection to the pharynx through a patent second pharyngeal pouch.¹²

Clinical Aspects: The lateral cervical anomalies may present as cystic swellings, as sinus openings, or as skin tabs containing cartilage. Lateral cysts are found beneath the anterior border of the sternomastoid muscle, usually in the upper or middle third of the neck. They are smooth and ovoid, and range in size up to 10 to 12 cm. in diameter. In the major-

TABLE I
ECTODERMAL DERIVATIVES OF THE BRANCHIAL COMPLEXES OF THE EMBRYO

	I	II	III	IV	V
Branchial Cleft	Ext. auditory meatus Epithelium of: Meatus Tympanic membrane (ext. surface)	Lost in cervical sinus	Lost in cervical sinus	Lost in cervical sinus	Lost in cervical sinus
Ectodermal covering of arch	Epidermis of tragus Maxillary process: Epidermis of upper lip and cheek Enamel Parotid gland Mandibular process: Epidermis of lower lip and jaw Enamel Submaxillary gland Sublingual gland Epithelium of: Vestibule, gum, palate	Epidermis of: auricle upper neck	Epidermis of: middle neck	Lost in cervical sinus	Epidermis of: lower neck

(Adapted from Arey, L. B., Developmental Anatomy, Saunders, 1942)

TABLE II
ENTODERMAL DERIVATIVES OF THE BRANCHIAL COMPLEXES OF THE EMBRYO

	I	II	III	IV	V
Pharyngeal pouch	Epithelium of: Tympanic cavity Tympanic membrane (int. surface) Mastoid cells Auditory tube (Thyroid arises in midplane at about this level)	Epithelium of: Palatine tonsil and fossa	Thymic reticulum and corpuscles Inferior parathyroid	Superior parathyroid	Ultimo branchial body
Entodermal lining of arch	Epithelium of: Body of tongue and much of mouth	Epithelium of: Root of tongue Pharynx	Epithelium of: Root of tongue Pharynx Epiglottis	Epithelium of: Root of tongue Pharynx Epiglottis	Lungs arise in midplane at about this level

(Adapted from Arey, L. B., Developmental Anatomy, Saunders, 1942)

TABLE III
MESODERMAL DERIVATIVES OF THE BRANCHIAL COMPLEXES OF THE EMBRYO

	I	II	III	IV	V
Skeleton	Maxillary process Upper jawbone Palate Dentine Cementum Mandibular process Lower jawbone Dentine Cementum Sphenomandibular ligament Malleus, incus	Stapes Styloid process Stylohyoid ligament Hyoid (body and lesser horns)	Hyoid bone (greater horns)	Thyroid cartilage thyrohyoid ligament Cuneiform cartilage	Thyroid (cartilage?) Corniculate Arytenoid Cricoid cartilages
Muscles (and their nerves)	Mastication M. digastricus (ant. belly) M. tensor tympani (Nerve V)	Expression Auricular Epicranial M. digastricus (post. belly) M. stylohyoideus M. stapedius (Nerve VII)	Pharynx (in part) (Nerve IX)	Pharynx and larynx (in part) (Nerve X)	Larynx (in part) (Nerve X)
Aortic arches	Stapedial A.(?)	External maxillary A.(?)	Common carotid Proximal internal carotid	Left: Arch of aorta Right: Subclavian (in part)	Pulmonary artery Ductus arteriosus (arch 6?)

(Adapted from Arey, L. B., Developmental Anatomy, Saunders, 1942)

ity of cases there is no connection with the skin, although occasionally a complete fistula may be found associated with the cyst, and if infection or suppuration has been present, secondary sinus openings may be found due to spontaneous rupture or surgical drainage. Presenting symptoms in these patients are usually those of a swelling in the lateral neck, at times first noted following upper respira-

tory infection, or operations upon the throat or tonsils. Pain, tenderness, redness, induration and local heat may be associated in those cases which present with acute inflammation. These patients, like those with the midline cysts, are in the younger age groups, the average age ranging from 25 to 35 years, although cases have been reported showing initial symptoms as late as 76 years.¹²

Sinuses and fistulae of the lateral neck are always present at birth. These lesions are found in the lower one-third of the neck, on a line along the anterior border of the sternomastoid muscle, and are commonly seen just above the sternoclavicular joint. The cutaneous orifice presents a tiny round or slit-like aperture, sometimes associated with a small pigmented area in the surrounding skin, and occasionally accompanied by a skin tab which may contain cartilage. Pressure above the opening usually causes a drop of mucoid or cloudy fluid to exude. Palpation of the orifice and deeper tissues above may reveal the presence of a small cystic swelling, or a cordlike tract may be felt running toward the pharynx. Presenting symptoms in these patients are those of persistent or intermittent drainage from a small opening in the neck, beginning at birth. Swelling in the neck may be present in those cases associated with cysts, and occasionally acute inflammation is seen. A rare case has been reported where dry, nonproductive cough formed a part of the symptomatology. Carp³ noted such an instance in a five year old boy whose cough was relieved by excision of the tract. Proximity of the fistula to the vagus nerve has been found in these cases. As these lesions are present at birth, patients are usually brought for treatment during early childhood, the average age ranging from four to seven years.

Differential diagnosis: Sinuses, fistulae, skin tabs, and cartilaginous rests in the lateral neck are rarely confused with any other lesion. They are always present at birth, cause little symptomatology unless infected, and are usually seen in children. Lateral cervical cysts, however, lie in an area where differential diagnosis may be difficult. Thyroglossal anomalies may usually be differentiated by their midline position. Cystic hygromas may lie in this area, but are usually less ovoid in contour, softer in consistency, and often extend posterior to the sternomastoid muscle, or down over the clavicle. They usually show transillumination of light, but this finding can be elicited in some of the larger, thin-walled cysts. Carotid body tumors are usually more deeply situated, of firm to hard consistency, and relatively fixed in vertical direction, but may be confused. Generalized cervical lymphadenopathy presents no problem, but involvement of one node high in the neck may be impossible to differentiate. Acute or suppurative adenopathy may be diagnosed by the finding of infection in the scalp, ears, throat, teeth, or jaws. Adenopathy of tuberculosis or lym-

phoma is usually multiple. Metastatic involvement of a single node in the lateral neck can usually be differentiated by its firm to hard consistency, and by the finding of a primary lesion on the skin of the head, in the mouth cavity, sinuses, or pharynxes, or in remote areas of the body. Chest x-ray is mandatory in these cases as such a lesion may represent the first sign of primary carcinoma of the lung. Lateral metastases from neoplasms arising in the thyroid gland can be confusing also. One case has been seen where diagnostic error was made, the lateral lesion proving to be a cystic metastasis from a papillary cystadenocarcinoma of the thyroid. The occurrence of this tumor in young individuals adds to the difficulty of diagnosis. As in the case of midline lesions, solid tissue found in the cysts at the time of operation should be subjected to frozen section examination before final treatment is carried out.

Treatment: Several anatomical varieties of the lateral cervical cysts and fistulae exist. Preauricular and auricular lesions have been excluded from this discussion. Anomalies of the first branchial cleft have been rarely reported until recent years,^{2,17,12} but form an important group of lesions in this area. They may present with swelling or fistula formation in the upper neck, and occasionally are associated with discharge from the external ear. Surgical therapy for this type of lesion involves the removal of the cyst or sinus opening, and the excision of the complete tract down to the external auditory canal. This tract in many cases traverses the parotid gland, and may run superficial or deep to the facial nerve. In some cases it may be necessary to remove a small cuff of the cartilaginous external auditory canal to insure complete excision. Careful dissection of the nerve fibers in this area is mandatory.

Skin tabs and cartilaginous rests of the neck are easily dealt with by simple removal, utilizing a transverse elliptical incision with closure by fine sutures. A deep tract must be carefully sought, however, as occasionally these integumental lesions are associated with sinuses or fistulae.

Cases with external sinus openings may represent complete fistulae to the pharynx, or may be short, blind sinus tracts. The complete fistula is more common, however, and one must search carefully for an upward continuation of the tract before terminating the excision at a low level. The procedure for the complete tracts begins with a transverse elliptical excision of the cutaneous orifice. The dissection is then deepened through the subcutaneous tissue,

platysma muscle, and the superficial layer of the deep cervical fascia. Slight traction on the tract will facilitate the dissection. The course of the fistula is then cephalad at this depth, lying on the anterior portion of the carotid sheath, until it reaches the hyoid level. At this point a second transverse incision is made, and the dissected tract delivered from below through this opening. The tract then courses inward to the pharynx, passing beneath the stylohyoid and the posterior belly of the digastric muscles. It runs between the internal and external carotid vessels, and may be found in varying relationship to the glossopharyngeal nerve. The internal orifice is located in the base of the tonsillar fossa. Dissection is continued to the pharyngeal wall where the tract is cut off and removed. Outward pressure from the pharynx by the anesthetist or assistant will facilitate this step. Closure of the wounds is accomplished by approximation of the platysma and the subcutaneous tissues with fine interrupted suture, and closure of the skin. One small rubber tissue drain may be left beneath the posterior belly of the digastric muscle and brought out through the lateral angle of the lower wound to be removed in 24 hours. The injection of dye or marking fluid has not been found to aid in the dissection of these lesions.

Congenital cystic swellings in the lateral neck may be found in conjunction with the complete fistulae, in which case the treatment is that outlined. The majority of the lateral cervical anomalies are simple congenital cysts, without tracts to either the pharynx or the skin. Simple enucleation will suffice to cure these lesions. It must be emphasized, however, that although statistically these simple cysts predominate, a smaller proportion of the cysts will show tracts to the pharynx, to the skin, or both. It thus becomes necessary in all cases to carefully trace any suspicious tissue, as a remnant of epithelium may give rise to recurrence. The cystic lesions are most easily removed through a high transverse incision in the skin creases of the neck. Adequate exposure is thus provided should the cyst prove to have a tract to the pharynx, and a good cosmetic result obtained.

Pathology: The cysts and fistulae of the lateral neck may show either entodermal structures derived from the pharyngeal pouch, or ectodermal structures derived from the cervical sinus. Thus one sees columnar epithelium, which may be ciliated, and squamous epithelium. Mucous glands or sebaceous glands are occasionally found. Cysts lined predominantly with columnar epithelium usually contain

mucoid material which may be high in cholesterol. Squamous lined cysts reveal grumous sebaceous material, and occasionally the presence of hair has been noted. Transitional types combining both these features are also found. Microscopically, one finds lymphoid tissue beneath either type of epithelium, and varying degrees of acute and chronic inflammation.

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NURSING CARE OF THE PSYCHIATRIC PATIENT IN THE GENERAL HOSPITAL

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CHANGES IN NURSE-PATIENT RELATIONSHIP

During the past quarter of a century a number of changes have produced important modifications of the relationship between patient and nurse. Perhaps the greatest and most fundamental factor has been the great advance in medical and surgical treatment which has placed an increased emphasis on technology. Much of the time spent by the nurse both in training and in practice is devoted to the acquisition of knowledge and skills which were not previously necessary. Nursing procedures are now so highly developed that a great portion of the time of the nurse is devoted to making objective observations and to keeping full records. Moreover, the duties of the nurse have been augmented through the increasing recognition of the value and capabilities of nurses to assume functions which at one time were those of the doctor. Again, the increased demands on the nurse require her as a student to spend a considerable portion of her time in the lecture room rather than with the patient. The introduction of the forty-hour week has further limited the time available to the nurse for forming a relationship with the patient, and this limited time is still further diminished by the shortening of the average time spent by a patient in the hospital as a result of modern methods of therapy. All these factors have resulted in a change in the traditional relationship between nurse and patient. The nurse is now often regarded as a technician trained to perform certain standard procedures rather than a person who "cares for" the sick person. Moreover, some of the efforts to increase the efficiency of the nurse appear to have resulted in a diminution of the expression of that warm human feeling which patients in the past have expected of the nurse. Although much has been gained in therapeutic efficiency, the change in the role of the nurse is undoubtedly felt by the majority of patients on the general medical and surgical floors. It is readily recognized that diminution of the personal element must be expected because of the pressures on the nurse. Indeed, there are so many individual procedures for each individual patient that the nurse is frequently "on the run."

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SUMMARY

This paper is a heart-to-heart talk by an expert psychiatrist to a group of nurses representing a cross section of the latter profession. The change in the role played by the nurse through the increasing emphasis being placed on technology is pointed out. Emphasis is placed on the need in the psychiatric hospital for the nurse to fulfill a more personal role. She must be kind and understanding to the extent she can contribute to the overwhelming distress of the patient suffering from a mental illness. The many other qualifications essential to a good psychiatric nurse are described, such as stability, absence of anxiety, lack of resentment and hostility. The nurse must recognize the human being in the patient and show a fundamental respect for him or her. She may have an unusual opportunity to talk with the patient when she must remain entirely objective in her approach. Finally, the psychiatric nurse must be informed as to the various therapeutic measures utilized and their effects on a patient.

The essential qualities are summed up by the author in four words: honesty, sincerity, understanding, stability.

In the psychiatric wards of the general hospital this trend has to be reversed, for the very nature of the illness demands that the nurse fulfill a more personal role. Essentially these patients are human beings whose difficulties are not easily understood either by the individual himself or others, and the help which the patient requires is basically that which can be provided by an understanding person.

PERSONALITY DEVELOPMENT OF PATIENT

It may be useful to give a brief account of personality development in order that the nurse may understand the unconscious elements of the patient-

nurse relationship. The very words "nurse" and "nursing" are identical with the care and the attention given by the mother to the child, and this identity in therapy is not merely accidental. Every human being begins life as a completely dependent person needing someone's help to take care of his every need. Inherent in becoming a human adult is the passage through a long period of dependency, from infancy to maturity, but nevertheless in the first few years of life each person encounters the prototypes of all the anxiety-producing situations which may occur throughout life. In these few years are developed the various techniques for allaying anxiety and for dealing with its causes; it is the integration of these techniques which form the ultimate personality. Anxiety and the causes of anxiety may be removed by numerous methods, the so-called "mechanisms of defense" which are built up as the child develops and changes his relationship with the parents. In early infancy certain primitive techniques are universal; for example, the infant regards any distress as the result of external forces—even abdominal pain or colic may be felt as due to a foreign body which has been ingested. More mature techniques are developed as the individual learns to relate himself to others and as he acquires more knowledge and experience of the external world and its inhabitants. Nevertheless his knowledge is limited and his interpretations are distorted because of his powerless and dependent position. Gratification of his needs are achieved only by conformity to overt behavior patterns held desirable by his superiors, while expression of his impulses draws down on him punishment in the form of physical pain by chastisement, or psychic pain by rejection or loss of acceptance. Thus, the child may develop a technique of inhibiting and repressing hostility and swing to the opposite extreme of being always pleasant and friendly, even, or more particularly with those he fears and resents. Thus, as the result of his experience, the child acquires the rules of conduct which the parents impose upon him, rules he internalizes to form the super-ego, or conscience. The super-ego is that part of the personality which controls impulses which if expressed would be unacceptable and which enables one to become a socially acceptable individual. There are, of course, many of these ego defenses which constitute in varying degrees the personality characteristics. The acts and behavior patterns of the normal adult are the results of resolution of anxiety which he removes

by using one or more of these "defenses." The integration of the individual in his home, his work, and his community depends upon his success in dealing with anxieties which arise in ordinary living. Some persons are better integrated than others, some use one method to a greater degree than others, but there is no person who may not at some time or another be called upon to face a situation producing anxiety with which he is incapable of dealing. When faced with such a stressful situation, the most recently developed techniques may prove ineffective and the individual may, therefore, fall back on methods previously discarded. It is the return to methods which might have been satisfactory in early years but are inadequate in adulthood that constitutes mental illness. The symptoms are the overt manifestations of the use of such defenses employed to deal with anxiety.

NURSING QUALIFICATIONS NECESSARY

If this is understood, if one realizes that this is what is happening with the particular patient, one should have only compassion and a desire to relieve the overwhelming distress. The part that the doctor or the nurse plays in mental illness is the assumption of the role played by the principal supporting figure at the time when these primitive defenses were utilized in the life of the patient, that is, in his early childhood. It is inevitable, therefore, that the patient relates himself to those caring for him, reliving the relationship which had existed with one or the other of his parents. Since it is probable that those who have developed a mental disorder in adulthood have in their childhood been exposed to continued and excessive anxiety in their relationships with the parents, the nurse must be prepared for a distortion by the patient of the role which she must play. She must endeavor to be, as it were, only the good, just and stable mother, although she must be prepared to accept the reaction of the patient when he behaves towards her as though she were also the bad, punitive or rejecting mother. If this be kept in mind, hostility, resentment, and rejection by the patient can be understood and need not be upsetting to the nurse. It is when the nurse has problems of her own in relating herself to others that her fears, anxiety, and resentment arise. Moreover, most patients who have developed emotional disorders, whatever the type, are extremely sensitive, and almost without fail they recognize in the nurse both her positive and negative reactions to them. Should the nurse

appear anxious, this can only increase the anxiety of the patient. If the nurse is resentful of a patient because he arouses anxieties in her, she may have considerably more difficulty in hiding it from the patient than from herself. For this reason not only the psychiatric nurse but every nurse should understand the nature of the processes active in interpersonal relationships between herself and others—patients, doctors, and colleagues.

EMOTIONAL RESPONSES OF PATIENT

All interpersonal relationships in which any person participates are basically founded on those which developed between the child and his parents and siblings. Within this group are aroused all the emotions, pleasant and unpleasant. The ego defenses represent the individual's attempt to remove or prevent anxiety arising in his relationships with the parents. A parental figure who is harsh and irrational in the emotional "eyes" of the child will produce an offspring who will endow all authority figures with the same attributes. In the course of normal development, certain corrective experiences may modify this tendency to distort, but generally excessive anxiety tends to interfere with the learning process. As the child grows with an ever widening circle of relationships, each person outside the family has had his prototype within the family: the teacher, the policeman, the nurse, the doctor or, indeed, any adult in a position of authority is in effect for the child a substitute for the parent. As the child passes into adulthood, further modifications of these relationships occur, but in many the childhood attitudes do, in large measure, persist. For this reason there exists the irrational anxiety which an employer or supervisor may arouse in one under his authority. The vigorous emotional reactions, both of like and dislike, which are aroused on first acquaintance have their origin in the distortions arising from previous unremembered experiences, usually on the childhood level—thus the inability of the individual to account for the fervor of his emotional response.

NURSE REACTION TO PATIENT

These parataxic distortions are particularly significant in a person who has a therapeutic relationship with another. A nurse undertaking duty on a psychiatric ward often has a great deal of insecurity and anxiety which is the result of both conscious and unconscious factors. There is the insecurity arising from the unknown, the entrance into a new world in which she must operate with grave responsibility

in relation to her supervisor and her patients. But she has also her own problems which she is solving with varying degrees of success. Now she is brought into close contact with other human beings whose difficulties are in many ways only exaggerations of her own, intensified to such a degree that they cannot be resolved in a controlled way. Consequently the behavior of the patient frequently rearouses conflicts which have previously been repressed, and to protect herself from external threats to her security, she unconsciously resorts to measures detrimental to the welfare of the patient. Thus, one may observe a nurse react to a patient in a hostile manner for no apparent cause; however, a knowledge and understanding of the nurse's own personality makeup may readily reveal the reason. It is interesting that examination of the reactions of nurses to patients illustrates all the mechanisms of defense in operation. Because these usually operate on an unconscious level, the nurse herself is unaware of the significance of her behavior.

Many examples spring to mind. Some patients in their efforts to deal with pathological anxiety attempt to relieve it by projection and rationalization; in their verbalizations they give what appear to be good and solid accounts which if accurate would convert the pathological condition into one of "normal" or understandable anxiety. The nurse whose drives or needs render her susceptible may identify with such a patient who to her appears no longer to be ill but to be struggling with a realistic situation. Sympathy or empathy leads her into actions at variance with sound psychiatric practice and even to encouragement of the patient in his delusional ideas.

On occasion the anxiety aroused by a particular patient may be so great that it is necessary for the nurse to alleviate it by the process of denial—denial that the person is ill, that he needs care and attention so that she is justified in spending more time with other patients. Likewise, defense by avoidance is utilized; that is, the patient may be overlooked or routine attention may be omitted.

Sometimes more active measures are used, again unconsciously. The nurse whose own problems are resolved on an obsessive compulsive basis will apply the same techniques in making the patient conform to an unnecessarily strict regime in matters of dress, neatness, and orderliness, or the nurse may project her own feelings onto the patient in other ways. Thus, one who does not have the capacity for warm

relationships may have difficulty with the apathetic patient, for lack of response arouses anxiety which she may resolve by forcing the patient beyond an optimum degree into activities or conversation.

Hostility, overt and hidden, may be directed against any patient who evokes anxiety in the nurse. It may be manifested by an overbearing or domineering attitude, by critical and hostile remarks, by deliberate inattention, or even by unnecessary forceful handling, or by chronic irritability. Many are the occasions when the hostility is less obvious but conveyed by a preference to pass time with other patients, by the performance of the minimum of duties, and by attitude, manner and tone of voice.

In a therapeutic relationship the solution of one's insecurity by the adoption of a patronizing approach has no place. One must also beware of allowing one's prejudices to interfere. The application of moral judgments applicable to the nurse herself must be avoided. The values, morals, and principles which an individual holds are the result of influences and experiences in his development. He is most condemnatory who needs to control his own impulses by self condemnation. Mental illness is the result of imperfect control of drives, instinctual and psychological, not socially acceptable to the person himself. During the illness the patient may express ideas or perform actions which in a normal situation he would consider undesirable, reprehensible, or even disgusting. Overt hostility in the patient is not justification for like reaction by the nurse; neither is it defensible to encourage a patient to talk about sexual matters for the vicarious satisfaction that may thereby be obtained. It must be admitted that for some nurses in their initial work with psychiatric patients the sexual problem is difficult. The present-day cultural beliefs that from adult sexual difficulties spring most emotional illnesses and that the psychiatric patient has decreased control over his impulses combine to render the nurse fearful of her safety. Brief experience with such patients on the psychiatric floor should soon disabuse her of these ideas and their persistence implies that perhaps the problem lies not with the patient.

Yet another source of difficulty may arise from her relationships with authority figures in the field. She may be over-anxious because of her fears of incurring the displeasure of the physician or the nursing supervisor. Sometimes her hostility to the physician or to the supervisor is unconsciously displaced from these persons to the hapless patient who

becomes the object of the expression of negative feelings.

If undue stress should appear to have been placed upon the difficulties encountered by the psychiatric nurse, the purpose has been to render her aware of the pitfalls which frequently may interfere with therapy.

POSITIVE QUALIFICATIONS NEEDED BY NURSE

Thus far there have been considered principally the negative factors which interfere with the nurse-patient relationship. For a positive therapeutic approach the desideratum must be the recognition that the patient is another human being who, as a result of both remote and recent experiences, has been overwhelmed by his or her problems; the patient is a person who is in need of help, who while perhaps suspicious of those who want to be of assistance, nevertheless is looking for someone who can help him overcome his fears. There must be fundamental respect for the patient, no matter how deteriorated, hostile, or rejecting he may appear; good psychiatric attention comes from the heart and not from the textbook. Understanding and awareness are necessary qualities. There should never with any psychiatric patient, or indeed with any patient, be conveyed the sense that a visit is solely a matter of duty and is to be terminated as soon as possible. A sense of hurry and urgency should play little part in a psychiatric ward. It is true that some patients will cling to the nurse or doctor far beyond a reasonable time, but it should be recognized that this arises because of the patient's need for reassurance.

The nurse is in a very good position to talk with the patient and thus to find out his particular interests and hobbies and methods of relaxation. About 2,000 years ago the functions of the psychiatric nurse were well described by Aurelianus who apparently recognized the value of consideration of the cultural factors in psychiatric therapy. He prescribed what should be read to patients and in what manner. He indicated that a laborer could converse much more easily about cultivation of the field while a sailor would be interested in navigation. He pointed out the necessity not to try to force patients beyond their capacity or intellectual knowledge, but instead to encourage them by recognition of their efforts. Aurelianus emphasized that the normal person should not have an exalted opinion of himself in comparison with the mentally ill human being. Interestingly enough, even in those days there

was criticism of the emphasis on medical routine rather than upon the patient as a total individual.

It is surprising how obvious fears of the patient may be overlooked or how seldom used are obvious methods of reassurance. For example, admitted to a ward with the door locked behind him, the patient is fearful because of the limitations on his freedom. The greatest reassurance that can be given is through contact with those in attendance, principally the nurse. He should be shown to his room, help should be given to unpack his clothes, and questions should be answered in a straight forward way. He should be familiarized with the routine; he should be taken around to be introduced to others; the plan of the ward should be explained to him. This may involve a considerable amount of time but nevertheless the first impression may color the whole of the patient's stay in the hospital. A friendly attitude, an acknowledgement each time the patient is seen, just as one would greet an acquaintance, all play an important part.

One of the most important functions of the nurse is to talk with the patient, allowing him to express his thoughts and feelings. Because she provides a bridge with the real world, she should listen patiently, yet be careful that she does not entwine her own problems with those of the patient. She should neither show agreement with false belief nor attempt to argue him out of them. Best of all is to divert his attention to topics less emotionally charged for him. It is possible to be sympathetic with the patient without being emphatic with his delusions.

It is important that the nurse be objective in her observations of the patient and of his behavior. She must be aware of his appearance, his verbalizations, both in form and content, his mood and his needs. She must be alert to notice changes in any of these and to remember to record them. She must realize the importance of charting significant actions and statements. She should know how important it is to quote exactly what the patient says when this is an

index of the degree of illness. She must be careful not to record as facts what she herself presumes or interprets. Some patients, for example, appear to be obviously hallucinated, listening to and answering voices not apparent to her. Only when the patient makes statements which definitely indicate the presence of auditory hallucinations can one, in fact, be sure. In other words reports must differentiate between that which the nurse interprets and that which is definitely expressed by the patient. Simple as this may seem, many nursing and medical reports are sometimes imperfect because of the lack of clear distinction. Such accuracy is particularly important because in some cases a confused or acutely disturbed patient may settle down in a relatively short period of time so that the psychiatrist may be completely dependent upon the nurse's report for a description of gross evidence of mental illness.

Moreover, to the nurse or to other patients may be expressed pathological ideas and emotions which are hidden from the psychiatrist because of the need to impress the latter that he, the patient, is not so ill as to require continued hospitalization. To promote this confidence in her the nurse must remember that to the patient she is a person who is stable and well adjusted and who is the one to take the initiative in social contacts.

Needless to say, the nurse must also know the routine to be followed in the various adjuvant treatments now available to the psychiatrist, such as electroshock, occupational therapy, etc. Immediately after shock treatment to remove a depression, the patient may be confused and fearful and reassurance at that time may be the beginning of a therapeutic relationship. A list of details to which the psychiatric nurse should attend has not been presented because it is held that if the basic philosophy of the nurse is correct, she cannot help but be an effective agent for good. The essential aim in dealing with psychiatric patients should be that the person be honest, sincere and understanding.

SEMI-ANNUAL COUNTY ASSOCIATION MEETINGS

Litchfield, Tuesday, October 4

TORRINGTON COUNTRY CLUB, GOSHEN

Social hour: 6:30 P. M.

Dinner 7:30 P. M.

Speaker and subject to be announced

Fairfield, Wednesday, October 5

WEE BURN COUNTRY CLUB, DARIEN

Business meeting: 4:30 P. M.

Dinner: 7:00 P. M.

Speaker: Mr. Robert Shaw, Lecturer, Playwright and Television Producer*Subject:* THAT MONSTER IN OUR LIVING ROOM**New London, Thursday, October 6**

MOHICAN HOTEL, NEW LONDON

Business meeting: 4:30 P. M.

Dinner 7:30 P. M.

Speaker: Arthur Tibbedeau, M.D., New England Medical Center, Boston, Massachusetts*Subject:* INTERESTING BONE DISEASES**Middlesex, Thursday, October 13**

RESTLAND FARMS, NORTHFORD

Business meeting: 4:30 P. M.

Social Hour and Dinner: 6:30 P. M.

Speaker and subject to be announced

Tolland, Tuesday, October 18

OLD HOMESTEAD INN, SOMERS

Dinner: 6:30 P. M.

Speaker: Dr. Edmund Zaglio*Subject:* NEWER IDEAS ON UPPER AND LOWER EXTREMITY PATHOLOGY**Windham, Thursday, October 20**

NATHAN HALE HOTEL, WILLIMANTIC

Dinner: 7:00 P. M.

Speaker and subject to be announced

Hartford, Tuesday, October 25

HARTFORD CLUB, HARTFORD

Social hour: 6:30 P. M.

Business meeting: 4:30 P. M.

Speaker and subject to be announced

New Haven, Thursday, October 27

WATERBURY COUNTRY CLUB, WATERBURY

Business meeting: 4:30 P. M.

Dinner: 7:00 P. M.

Speaker: Honorable Cyril Coleman of Hartford, Connecticut*Subject:* PROFESSIONAL LIABILITY INSURANCE IN CONNECTICUT

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EDITORIALS

Medicine's Stake in Social Security

The fact that the recently proposed changes in the Social Security Act, passed by the House of Representatives by a vote of 372 to 31, were not acted on by the Senate in the session of Congress just ended does not remove the threat that such legislation carries to the practice of medicine. It is a foregone conclusion that this bill will be acted upon by the Senate by the first of next year. The implications of this bill are enormous and far reaching for the proposal would establish, for the first time in this country, a system of national compulsory disability "insurance" under Title II of the Social Security Act. To quote a recent editorial in the *Journal of the American Medical Association*: "Because of the piecemeal approach to the socialization of medicine, of which this proposal is the key-stone, the medical profession and the nation as a whole have not been as alert to the danger as they were during the 1949-50 campaign against the Truman-sponsored compulsory health insurance bills. The present danger, in fact, is greater.

"If this bill is adopted it can be confidently predicted that the cash disability benefits will gradually be extended to the temporarily disabled and that eventually the federal government will initiate a system of compulsory health insurance as a necessary counterpart to the cash benefits program. This combination of national compulsory health insurance and national disability benefits has been true in almost every other nation where government disability benefits exist. The combination becomes inevitable because the government must control the treatment of the disabled if it is to maintain any control over the extent of the cash benefits."

Because the present bill requires that cash benefits be contingent upon participation by the disabled in rehabilitation programs, the medical profession should become thoroughly aware of the true nature of the bill and its effect on health insurance and medical practice.

Social Security is not insurance; it is but another form of taxation. The system is still young. It has a surplus of \$22 billion in its accounts but this money has all been spent and has been replaced by government bonds which must be paid off by more taxes. Moreover, the reserve fund will fall far short of meeting pension requirements long before the majority of present taxpayers come to collect. The remainder of the money will have to come from social security taxes paid by our children and grandchildren at constantly increasing rates.

The something-for-nothing implications in the new Social Security bill would lower the pension eligibility age for women from 65 to 62 years, and the payment of pension to totally and permanently disabled persons after they reach the age of 50. Such disabled persons now are relieved of further pension taxes, but must wait until they are 65 to collect. These new provisions will affect about 1,300,000 persons to whom the payments will be largely velvet. But to those who continue to work the costs will steadily increase. Under the bill social security tax rates will be increased January 1, 1956 so that the employer and employee together will have to pay five per cent of every pay check into the fund. By 1975 the tax will have been increased to nine per cent of the nation's payroll.

The ultimate goal advocated by our national labor organizations may be the program embodied in the

"Minimum Standard for Social Security" convention adopted at the annual meeting of the International Labor Organization in Geneva in 1952. They are:

1. Old-age and survivor benefits which we already have in this country. The amount of benefits, however, would provide a comfortable living rather than a mere subsistence level to be supplemented by individual efforts;

2. Permanent and total disability benefits;

3. Weekly benefits for unemployment from any cause, whether inability to secure a job, sickness or accident either occupational or nonoccupational. This means of course the socialization and nationalization of our present workmen's compensation system;

4. Maternity benefits;

5. A monthly payment to each family for each dependent child;

6. A lump-sum job separation payment; and

7. National compulsory health insurance or socialized medicine.

The fact that this last Social Security bill is a threat, not only to medicine, but to our entire social economy is evidenced by opposition expressed in the press by two newspapers supporting such divergent political views as the *Chicago Daily News* and the *Chicago Tribune* as well as in a recent issue of *American Economic Security*. The statement by the Board of Trustees of the AMA warrants careful consideration by every physician. It is this: "The distance between our present medical freedom and complete government regimentation has narrowed considerably. The remaining gap will be closed completely unless physicians throughout the nation take constructive action to educate themselves, the public, and their congressmen and senators during the next few months."

This we must do and do it now. January, 1956 is not far off.

Hypokinetic Disease

If one takes no stock in the statement that our mechanized life leads to physical inactivity which in turn is a large factor in a number of disease entities, one had only to visit the exhibit on hypokinetic disease recently displayed at the Atlantic City session of the American Medical Association. Certain muscle tests were demonstrated to gauge physical

activity and these were used as a means of predicting the incidence of hypokinetic disease in a population. In appraising the muscular fitness of school children in Eastern Seaboard States, more than 50 per cent failed basic muscle tests as opposed to less than 10 per cent failure in comparable groups abroad. The exhibit pointed out that study, treatment and prevention of physical activity as an important factor of many disabling diseases is imperative for our national welfare.

The European has been forced to a much greater degree of physical activities since there are no school buses, no mechanical aids, no passive entertainment available. One of the European groups enjoyed no physical education at all and yet, in spite of it, physical activity of every day living was enough to keep members of this group in good physical condition.

The majority of our population falls into the sedentary group. The physically active show better adaptability to stress, less neuromuscular and emotional tension, and lesser fatigability. They age later, do not tend to absolute and relative overweight. The blood pressure is lower, they are stronger, more flexible and they have a greater breathing capacity and a lower pulse rate.

Studies by J. N. Morris *et al.* in England and Wales show that coronary disease is twice as frequent in the sedentary as in the active. Other diseases found to be more frequent in the sedentary than in the active are diabetes, duodenal ulcer, and a number of other internal and surgical conditions.

The group at New York University found that 80 per cent of low back pain is due to lack of adequate physical activity. Using a group of West Point cadets who were discharged with psychiatric endorsement as a basis for study, it was found that lack of physical fitness goes parallel with emotional difficulties.

Almost 60 per cent of our urban and suburban school children and more than 40 per cent of our rural school children failed their muscle tests while less than 10 per cent of urban and suburban European school children failed.

To correct this state of affairs the exhibit emphasized that muscle tests should be part of the evaluation of our patients, that a balance between intake and outlet should be attained by increased physical activity and not by diet and rest alone, and that physical activity and exercise should be prescribed

whenever indicated. Parents should encourage free play, walking, running, active entertainment, and should avoid the use of play pens and strollers, car rides and passive entertainment. Physical activities in schools should be increased. Formal exercises should be stressed rather than permissive games. Safeways should be provided for children to and from school instead of school buses.

Are we in this country becoming a soft sedentary race? The exhibitors at Atlantic City had much objective material to prove this is true.

A Premature Babies Milk Bank

The pediatric staff at Evanston Hospital, Evanston, Illinois, together with the Junior League of Evanston, Inc., conduct a Premature Babies Milk Bank which is believed to be unique. This bank is absolutely free, and the breast milk is made available to all premature and sick babies at the Evanston Hospital or any other hospital in the Chicago area. Milk is given without charge by the donating mothers, who pump in their own homes without supervision, and it is given without charge to the infants who need it. There are about 100 breast milk banks in operation throughout the world—seven of them in the United States—but these are not free banks. Either the donor is paid, or there is a charge for the milk supplied, or both.

The Evanston group undertook the task of making a survey of milk banks around the world and the correct status of breast feeding. Some of the results of this survey are interesting. The comments of a great majority of physicians canvassed here and abroad indicate the belief that "breast milk has specific protective factors." In the opinion of 41 physicians abroad, breast milk does save lives. The range of breast feeding in foreign countries queried was found to be from 51 to 90 per cent, while the percentage of premature breast fed ran from a "majority" to 99 per cent. The startling fact was discovered that the majority of babies are breast fed in every country from which information was obtained except Belgium and the United States. The largest milk bank reported was in Brussels where 17,919 liters are collected annually. The Evanston bank has collected 22,921 ounces over a period of 17 months.

The Evanston bank provides all the breast pumps without charge. Junior League volunteers deliver a pump to a home and explain its operation. These

volunteers also deliver sterile bottles to mothers supplying milk and pick up the milk regularly for delivery to the hospital. Arrangements for donating milk are made through the pediatricians or the nurse in charge of the hospital nursery. The Evanston group also supply a complete list of directions illustrated showing how to breast feed a baby.

This project within our own country is the more compelling of attention because of the conflicting opinions expressed by pediatricians as to the value of breast feeding. Even if this procedure is not of unquestionable value to the baby, it has been noticed by gynecologists that it contributes to more rapid involution of the uterus and healing of vaginal lacerations and episiotomies.

Diabetes Mellitus — A Symptom-Complex

Diabetes mellitus is an old story. The ancient Hindus called it the honey-urine disease, Avicenna in the fifteenth century noticed the sweet taste of the urine, and Matthew Dobson, in that never-to-be-forgotten year 1776, proved that the saccharine flavor was due to sugar. When, in 1889, von Mering and Minkowski demonstrated experimentally that ablation of the pancreas in animals led to the disease, it seemed as though the problem of its etiology had been fathomed. But "things are not always what they seem," and later experience, both experimental and clinical, has shown that secretions of three other endocrine glands—the pituitary, the thyroid, and the adrenal—may cause or modify the typical diabetic picture. This may be defined as hyperglycemia and glycosuria with, at times, dehydration, ketonuria, and even diabetic coma. Inasmuch as all three glands are subject to diseases which may either increase or decrease certain hormones, it is only natural that abnormalities in these secretions may modify diabetes either favorably or unfavorably.

The pituitary association of diabetes mellitus is with disease of the anterior segment. Houssay, in his classical experiments, demonstrated that diabetes in animals is intensified by the injection of extract of the anterior pituitary. Clinically acromegaly, which is associated with increase in the secretion of the basophilic cells of the anterior pituitary, may be associated with diabetes mellitus or may aggravate

See Amer. Jour. Med., Special Diabetic Number edited by Russell M. Wilder and M. D. Pareira, 7:596 (1949); and Probstein, J. G., Ann. Surg. 133:299 (1951).

pre-existing cases. Successful treatment of acromegaly by radiation may rapidly ameliorate the diabetes. There is some evidence too that spontaneous degenerative changes in the anterior pituitary in man may result in amelioration of coexisting diabetes, though such an occurrence is undoubtedly rare.

The occasional concurrence of diabetes with hyperthyroidism, particularly Graves' disease, is an old observation, and it has been noted that even without the actual development of the complete diabetic syndrome the sugar tolerance curves may resemble those of mild diabetes. As Balfour and Sprague point out, the development of diabetes may so mask the symptoms and signs of hyperthyroidism that these are overlooked. For this reason any new patient with controlled diabetes who continues to lose weight and develops fatigue and nervousness should be tested for evidence of hyperthyroidism. In contrast to such patients, those with myxedema, either spontaneous or postoperative, may develop great amelioration of pre-existing diabetes and the control of the hyperthyroidism may result in reactivation of the diabetic picture.

Following ablation of the adrenals in animals with experimental diabetes, there is real improvement in the diabetes with increased sensitivity to insulin similar to that produced by hypophysectomy. The full intensity of the diabetes can be restored by the administration of suitable doses of adrenal cortical hormones which have carbohydrate activity, such as compound E (17-hydroxyl-11-dehydrocorticosterone) or compound F (17-hydroxycorticosterone). Patients who have coexisting Addison's disease and diabetes mellitus show similar results in varying degree. They may present marked remission in their diabetic symptoms and increased insulin sensitivity. Sometimes the diabetes completely disappears. Under hormone treatment for the adrenal symptoms the diabetic syndrome may recur. On the other hand, patients with lesions associated with hyperfunction of the adrenal cortex and the production of hormones with carbohydrate activity may develop diabetes mellitus of a special type characterized by relative insensitivity to insulin but easily influenced by starvation.

In addition to types of the diabetic syndrome clearly associated with endocrine abnormalities, there are certain other varieties, sometimes transient,

the exact origin of which is not so clear. It is known, for example, that starvation may result in ketosis and other evidences of diabetes, especially after resumption of carbohydrate feeding. As Pareira and Probst point out, Claude Bernard describes this phenomenon in fasted animals and Tolstoi and others have observed it in man. This is the so-called "hunger diabetes." Then too the occasional association of the diabetic picture with trauma has long been known, and this type may follow either accidents or surgical operations. It may possibly be a form of hunger diabetes. Furthermore the occasional development of a diabetic syndrome following infections is an old observation. Years ago the occasional association of diabetes with appendicitis was reported and more recently it has been noted with other infections. In the types above discussed the lack of examination for signs of diabetes prior to the development of the diabetic syndrome may leave the observer in doubt as to whether the trauma or infection may not have merely lighted up a latent diabetes.

The gist of the whole discussion lies in the fact that diabetes mellitus should not be regarded as a specific disease entity with a fixed and unalterable etiology but rather as a symptom complex which may result from a variety of causes. A similar situation has been shown to prevail in some other conditions originally regarded as specific diseases, cirrhosis of the liver, for example, and in all likelihood will, with increased study and experience, be shown to be true of other so-called diseases.

G. B.

William B. Sweeney Dies

William B. Sweeney, 67, a leader in New England hospital circles for many years, died suddenly at his home in Willimantic on September 2. At the time of his death, Mr. Sweeney had completed 22 years of service as Superintendent of the Windham Community Memorial Hospital. He was a former secretary and president of The Connecticut Hospital Association and held membership in the American Hospital Association and the New England Hospital Assembly. He was also a Fellow of the American College of Hospital Administrators, having held membership in this society of his profession since 1936. Medicine will miss this efficient administrator.

PROGRESS IN CLINICAL MEDICINE

NEW HORIZONS IN CANCER RESEARCH

JOHN R. HELLER, M.D., *Bethesda, Maryland*

The Author. *Director of National Cancer Institute,
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RECENT advances by research on cancer and other medical problems make possible the cure of more cancers than could be managed effectively 15 or 20 years ago. For example, increases are noticeable in the cure rates for cancers of the breast, uterus, and stomach, and for certain cancers of the head and neck. In addition, new palliative measures have improved the outlook for the advanced cancer patient.

Improvements have been made, too, in the management of some of the leukemias. While it is true that more people are recovering from cancer, the fact remains that the gains have been made largely in the localized, external, and accessible cancers; the disseminated and less accessible remain beyond the effective reach of presently available methods of treatment.

Altogether, about one-fourth of patients with cancer today, receiving proper medical care, are being cured. The most optimistic estimates of results that could be obtained with the earliest application of surgery and of radiation in all patients would perhaps double that figure. To save the remaining one-half we must look to the advances of future research.

LABORATORY RESEARCH

The tasks of researchers in this field are exceedingly complex, for cancer is not a single disease but many types of disease with the malignant characteristic in common. The research effort that has been mobilized against cancer represents the major branches of sciences. It would be impossible for me to discuss all of its aspects, so, instead of attempting the impossible, I would like to illustrate the diver-

sity of cancer research by pointing out a few of the multitude of the approaches employed by investigators in this field.

A large and vital part of cancer research comprises the laboratory studies which are focused on fundamental problems related to: (1) carcinogenesis—the process by which normal cells are transformed into malignant; (2) the nature of the cancer cell, and (3) tumor-host relationships—the changes that occur in an organism in which cancer is developing or has become established. Studies in the laboratory by the chemist, the biologist or the physicist may not look at all spectacular in comparison to those conducted at the patient's bedside. Many of these studies may bear little or no apparent relation to human cancer. Yet the solutions to the practical questions regarding the prevention, diagnosis, and treatment of cancer in man are largely dependent upon the clarification of the fundamental problems.

There are many examples of fundamental studies that have advanced cancer knowledge, although when initiated they had no apparent application to human cancer. For example, the cytologic test for uterine cancer is the culmination of painstaking and long-term investigation in the basic sciences of cytology and morphology. Another example is the radioactive isotopes, which the U. S. Atomic Energy Commission distributes. These sensitive tools, with applications in cancer research, diagnosis, and treatment, are by-products of developments in atomic energy.

One could cite many other fundamental advances that have swelled the reservoir of knowledge of cancer. To name a few: the electron microscope's revelations on viruses and on cell structure; the demonstration of hereditary influences in the production of experimental cancer; the transplantation of human cancers into laboratory animals; and the

Excerpts from paper presented at the Ninth Annual Meeting, Texas Division, American Cancer Society, San Antonio, Texas, January 28, 1955

development of ingenious techniques for applying tissue culture to the study of clinical cancer problems.

SURGERY

In addition to advances in laboratory research, cancer investigators have reported encouraging progress in the search for better methods of treatment and diagnosis. During recent years, cancer therapy has been expanded by the heroic extensions of surgery, advances in radiology, and the introduction of new agents such as anticancer drugs and hormones.

Remarkable refinements and improvements have been made in cancer surgery. More radical surgery has emerged as an important development and has expanded the concept of operability. As a result, many operations once regarded as maximum procedures have become commonplace and some never seriously considered before are being done with reasonable safety. In addition, the adrenalectomy and other palliative operations have been devised for use when direct attack on a tumor is not possible.

Many factors other than better operative techniques have contributed to the improvements in cancer surgery. Among these are better anesthesia, wide use of antibiotics to control infection, improved management of shock and hemorrhage by blood transfusions, and the improvement of surgical hospital facilities.

RADIATION

Numerous advances have been made in the evolution of radiation therapy of cancer. Techniques for x-ray and radium therapy have been standardized. A large body of knowledge of the radiosensitivity of almost all forms of cancer has been accumulated. New techniques in radiation therapy as well as new sources of radiation have been introduced.

Two of the new techniques in therapy are especially important. One of these involves the placement of the patient in such a position that he may be rotated during exposure to the radiation beam so that the tumor is at the center of rotation in line with the beam. The second is the use of supervoltage equipment in the form of multimillion volt x-ray generators, the betatron, or multicurie cobalt or radium teletherapy units. Evaluation of the rotational and supervoltage techniques is underway at a number of medical centers, but it is too early to say if they offer substantial improvements over other methods.

Radiation is no panacea. Many cancers regress under the bombardment, others are radiation resistant, and some may even be stimulated by radiation to more vigorous growth. Experiments using laboratory animals are in progress which are increasing our understanding of the biological effects of radiation. In addition to their importance for cancer research, such studies are, of course, needed because of the development of atomic energy weapons. Especially important to both areas are studies on radiation sickness. Recently it has been found that shielding of the spleen or bone marrow or the prompt administration of nonirradiated spleen or bone-marrow material to laboratory animals exposed to a normally fatal dose of radiation can prevent or counteract many of the usual consequences of such exposure. These findings give new leads to possible means of protection against large amounts of radiation.

CHEMOTHERAPY OF CANCER

One of the most encouraging aspects of progress in cancer research during the last ten years has been the rapid development of a number of useful chemical agents. These are not "wonder" drugs; none can be considered a cure for any form of human cancer. Nevertheless, the use of these agents has contributed significantly to the comfort of patients, in certain cases prolonging life and in many cases permitting periods of useful living not possible before.

The rate of investigations in chemotherapy of cancer has increased so much that today this ranks as one of the main areas of cancer research. Investigations in this area are of two broad types: fundamental studies of normal and abnormal growths, and the empiric trials of chemical compounds against tumors. If, through biochemical and metabolic studies, the function of cancer and of the tumor-bearing host can become thoroughly understood, a chemotherapeutic approach may evolve from this understanding; or the systematic testing of compounds may lead to a successful drug prior to a thorough understanding of cancer. Both approaches merit continued support and effort.

Investigators engaged in research on chemotherapy of cancer must overcome a number of imposing difficulties. One is the lack of an adequate laboratory test, subject, or method. Numerous techniques of screening and testing compounds on tumors in experimental animals have been used. Through chemotherapy screening programs at the Memorial Cancer Center, the National Cancer Institute, and

elsewhere, more than 12,000 compounds have been tested and hundreds been found to damage tumors. There is no clear relation, however, between the responses of animal tumors and the therapeutic effectiveness in man. If human cancers could be transplanted to animals, a better screening of compounds might be possible. Recent work on the transplantation of human tumors in laboratory animals, such as that of Dr. Helene Toolan at the Sloan-Kettering Institute and Dr. H. S. N. Greene at Yale University, gives promise of providing the preparation of human cancer cells that may be essential to suitable antitumor screen.

The agents having an established role in the chemotherapy of human cancer can be classified as: (1) those which alter the hormonal environment of organs such as the breast and prostate, where certain cancers have been found to be hormone dependent; (2) the cell poisons; and (3) those which function as antagonists to the metabolic incorporation of substances essential to cell growth.

HORMONAL ALTERANTS

The sex hormones are being used in the treatment of some forms of cancer of the breast and prostate. In cases of disseminated prostatic cancer, castration and the administration of estrogens have given notable improvement and increased life expectancy as much as three or four years. This advance in therapy is based upon the work of Huggins, who was among the first to demonstrate that induced imbalances might have marked effects on some types of cancer. Huggins has extended his research to the trial of bilateral adrenalectomy in patients with prostatic or breast cancer refractory to other therapy and has obtained improvement in their condition for variable periods of time.

Through studies by many investigators in the United States and foreign countries, the effects of hormone therapy of advanced breast cancer have been delineated. There is evidence that the life span of patients with advanced breast cancer is prolonged by an average of at least six months by the use of estrogens or androgens. Unfortunately the beneficial effects of hormones are temporary in most cases, but there is hope that present studies will lay the ground work for hormonal cure of certain specific cancers.

Many interesting studies of hormone therapy are underway or have been completed recently. A great deal of work has been done in both clinical and laboratory cancer studies with ACTH (adrenocorti-

cotrophic hormone) and cortisone (Compound E). At present, their main use in cancer appears to be in combination with the folic acid antagonists, myleran, or 6-MP in the management of acute lymphomas. However, West and others at Sloan-Kettering have reported findings indicating that cortisone treatment benefits patients with advanced breast cancer. In other promising research, Hertz at the National Cancer Institute has found massive dosages of estrogen beneficial to certain patients with breast cancer.

CELL POISONS

Perhaps the most widely used of the cell poisons are the nitrogen mustards. They are useful in the temporary arrest of Hodgkin's disease, lymphosarcoma, and chronic leukemias, and have some effectiveness in cancer of the lung. A promising derivative of nitrogen mustard is triethylene melamine (TEM). It appears to be effective in the same types of cancer which respond to nitrogen mustard. Another promising new agent is myleran, which has given beneficial effects in granulocytic leukemia.

METABOLIC ANTAGONISTS

Perhaps the best known of the metabolic antagonists are the antifolic acid compounds, aminopterin and amethopterin. Their usefulness in the treatment of acute leukemia in children has been demonstrated by work at Children's Medical Center, Boston, and at many other clinics. As is true of other anticancer drugs which have been tried clinically, resistance to the antifolics invariably develops after a time, and retreatment becomes ineffective. Nevertheless, antifolic treatment has extended the average survival in children who do respond by more than one year. A new addition to the group of useful metabolic antagonists is 6-mercaptopurine (6-MP). Results reported in the past few months indicated that 6-MP is a useful agent in the treatment of leukemia and that, in contrast to the antifolics, its activity is not restricted to childhood.

Attempts are being made to overcome the phenomenon of resistance by the use of combinations of drugs. The general idea behind combination therapy is to use a second drug to knock out cancer cells that resist the first drug—or to use a third drug to kill those that survive the first and the second. Research on this and other problems in the chemotherapy of cancer is apt to progress slowly and should be viewed as a long-term effort. Yet we feel that enough work has been done to indicate that

chemotherapy is not a hopeless approach to cancer control. Expectations that more effective agents will be developed are better justified today than ever before.

DIAGNOSIS OF CANCER

Because the curability of cancer is closely related to early diagnosis the problem of finding a good screening test is an urgent one. An ideal solution would be the development of a blood test like the Wassermann—a test which can be applied on a mass basis at reasonable cost and is specific enough to identify a high percentage of cancer cases at an early stage.

Since 1948 numerous diagnostic tests have been devised and evaluated in research fostered by the National Cancer Institute. So far no general chemical test accurate enough for practical cancer diagnosis has been developed. A few tests, however, show enough correct results to warrant continued investigation.

While a general diagnostic test appears to be still in the future, notable progress has been made in the development of tests to aid in the diagnosis of cancer of specific sites. One of the most practical of these is the cytologic examination developed by Papanicolaou and Traut. This test, often called the Papanicolaou smear, is a method for detecting malignancy by microscopic examination of shed cells collected from body fluids.

Cytologic diagnosis has come of age in a relatively short time. In the last ten years, it has been successively viewed with alarm, embraced with affection, extended to a variety of tissues, and pronounced a requirement for certification in pathology. Today the everyday usefulness of cytology as a complement to other diagnostic procedures is widely recognized, and more and more clinics, hospitals, and physicians in general practice are using it routinely, particularly in detecting cancer of the uterine cervix.

OTHER USES OF CYTOLOGY

The original cytologic technique has been varied and extended to facilitate the early detection of cancer in other sites, such as the lung, the bladder, and

stomach. Gastric cancer is the first-ranking cause of cancer deaths among men. The development of a good diagnostic procedure for this type of cancer is essential since conventional methods discover only about one-fifth of the cases at an early stage. Toward this end, several unique methods have been devised for obtaining material from the stomach for cytological study. One is the papain lavage developed by Traut and Rosenthal of the University of California. Their method consists of washing the patient's stomach with a solution of papain, an enzyme which dissolves the mucus on the stomach lining and frees cancer cells trapped by the mucus. More recently, Ayre and Oren have developed a rotating gastric brush which they describe as a potential tool in office screening procedures. The brush can be inserted through the patient's mouth into the stomach and rotated to secure fresh cells for study.

CANCER MORBIDITY SURVEYS

The need for further improvements in diagnostic techniques is great. Most cancers still are being diagnosed at a moderately or well advanced stage. One-half of all cancers develop in sites accessible to direct examination by the physician: the mouth and pharynx, thyroid, breast, skin, prostate, uterus, and rectum. Yet, according to our surveys of cancer morbidity in Dallas and nine other metropolitan areas, only 50 per cent of the cancers developing in accessible sites, excluding the skin, are being discovered in an early stage.

CONCLUSION

To sum up: one of the most extensive scientific efforts in medical history has been mobilized against cancer during the past few years. Advances have been made in many of the types of research embodied in this vast effort. Although the problems still unsolved in cancer research are serious and complex, we have ample reasons for believing that the continuation of this cooperative effort will lead to the solution of these problems. We can be confident, too, that progress in this endeavor will be accelerated while the American Cancer Society and the National Cancer Institute continue working hand in hand, as in the past, with understanding and co-operation.

THE PRESIDENT'S PAGE

AUGUST 19 and 20, 1955 will long be remembered as the date of the most devastating flood in Connecticut's history. Destruction in Waterbury, Putnam, Winsted, Torrington, Hartford, Derby and other towns in this area was fantastic. Homes, factories, stores, bridges and roads were wrecked and torn up. Automobiles, trains and other mobile objects in the areas near the rivers were washed away or wrecked. Heroic rescues by boat, helicopter, breeches buoy and even pick-a-back removed imperiled people from their precarious perches on doomed structures, keeping the loss of life to a minimum.

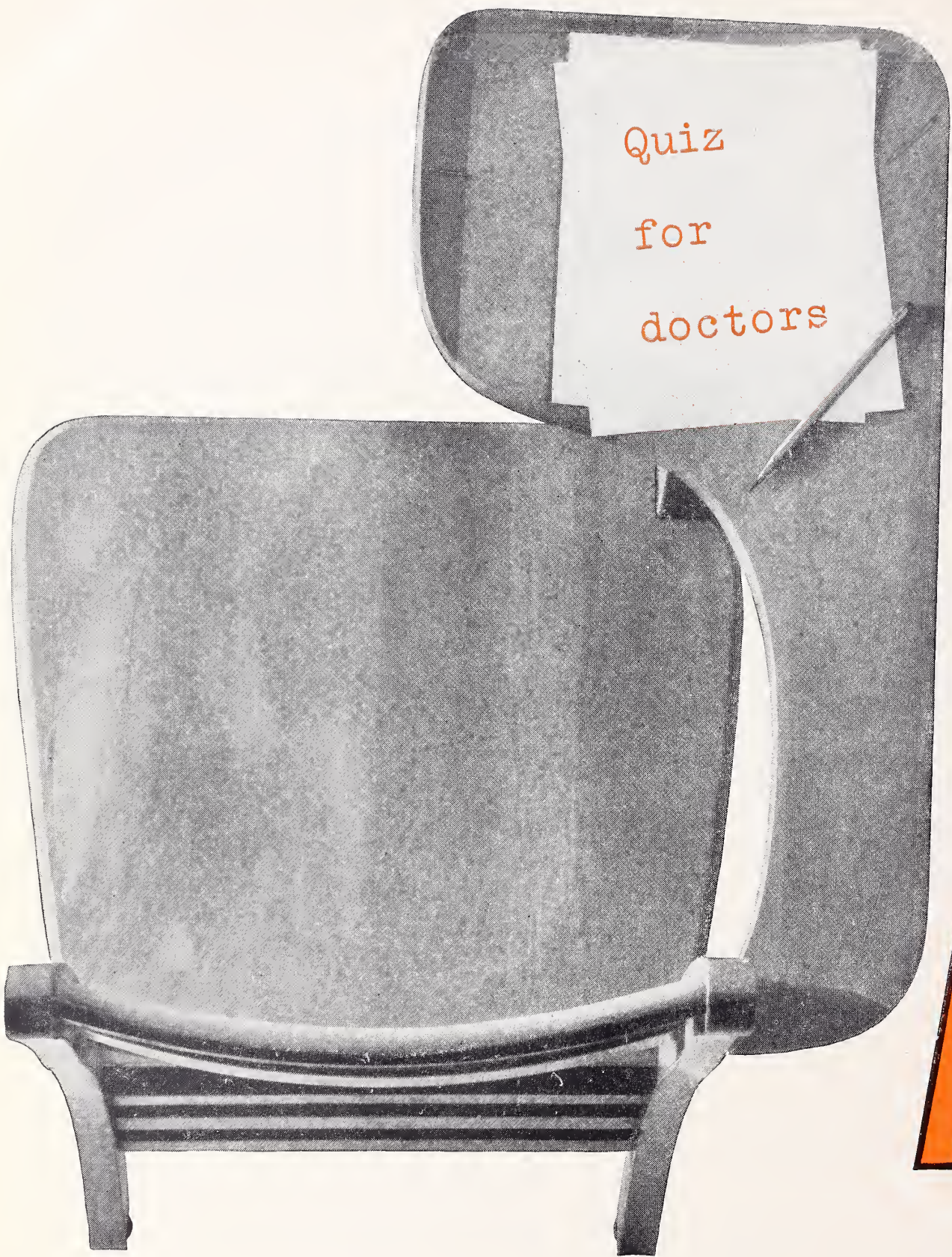
As the floods receded, the sight of the damage was heart breaking. Debris of all descriptions littered the path the flood had taken. In Putnam the skeleton of a burned-out magnesium plant stood as stark evidence of the calamity which befell this town. Other problems presented themselves. Electrical service and water supplies were disrupted creating problems of sewerage disposal and food contamination, thus establishing a menace to the health of the people. In the face of all these problems what happened?

Throughout the State and Nation, people, such as you and I, answered the call for help. The Red Cross, our State Department of Health, the local Health Departments, volunteer physicians, nurses and other volunteers, all worked together thus preventing a major health disaster.

Most of all though was the reaction of the people in the devastated areas. Recognizing their problems and taking stock of what had to be done, they tightened their belts, lifted their chins and together began to rebuild their factories, churches, schools and homes, always looking forward to better things to come. They are proving the truthfulness of the statement of President Eisenhower when he said: "This is a chance where each of us can rise to an emergency and prove that the American people, regardless of governments, regardless of limitations on them, can meet an emergency and do it well."

The Connecticut State Medical Society salutes those of the flood areas for their courage in the face of disaster and extends its sympathy to those who lost loved ones. Any services we can render in this rehabilitation, I assure you, will be forthcoming.

Oliver L. Stringfield, M.D.

A stylized, dark grey illustration of a chair with a curved backrest and a seat. A white rectangular sign is attached to the upper part of the backrest. The sign contains the text 'Quiz for doctors' in a red, typewriter-style font. A thin, dark line, possibly representing a pen or a string, is visible near the sign.

Quiz
for
doctors

AC

(you probably know every answer!)

Q. Which is today's most widely prescribed broad-spectrum antibiotic?

A. ACHROMYCIN — it's first by many thousands of prescriptions.

Q. What are some of the advantages of ACHROMYCIN?

A. Wide spectrum of effectiveness.
Rapid diffusion and penetration.
Negligible side effects.

Q. Exactly how broad is the spectrum of ACHROMYCIN?

A. It has proved effective against a wide variety of infections, caused by Gram-positive and Gram-negative bacteria, rickettsia, and certain viruses and protozoa.

Q. In what way are ACHROMYCIN Capsules advantageous?

A. For rapid and complete absorption they are dry-filled, sealed capsules (a Lederle exclusive!) No oils, no paste...tamperproof.

Q. Who makes ACHROMYCIN?

A. It is produced — every gram — under rigid quality control in Lederle's own laboratories and is available only under the Lederle label.

ACHROMYCIN*

Hydrochloride
Tetracycline HCl Lederle



LEDERLE LABORATORIES DIVISION AMERICAN *Cyanamid* COMPANY PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

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Council Meeting

A regular meeting of the Council was held at the offices of the Society on September 15, 1955. The meeting was called to order by the Chairman at 5:00 P. M. There were present in addition to the Chairman, Dr. Fincke, Drs. Stringfield, Ogden, Barker, Gibson, Feeney, Marvin, Gallivan, Ursone, Tracy, Russell, Archambault, Gens, Clarke, Meyers, Buckley, Dwyer, Starr, Gilman. Absent: Drs. Couch, Weld, Danaher, Murdock, Flaherty, Ottenheimer.

The Budget Committee for 1956 was appointed, Chairman Frank H. Couch, F. Erwin Tracy, Stanley B. Weld and Creighton Barker. The Committee will present its report to the Council at the next meeting.

It was voted that the semi-annual meeting of the House of Delegates be held in New Haven on December 8. Noted, that Dr. Gibson, Speaker of the House, cannot be present on that day and that the Vice Speaker, Dr. Feeney, will preside.

It was voted that a contribution of \$50 be made to the Massachusetts Medical Society to help defray the cost of breakfasts during the AMA meeting in Atlantic City in June 1955.

The report of the Committee on Third Party Payments (AMB 9/15/55 "A") was accepted after discussion of the desirability of committees such as the Committee to Study Third Party Payments for Medical and Ancillary Non-Surgical Services serving as subcommittees of the standing Committee on Third Party Payments in the future.

On recommendation of the Committee on Industrial Health, it was voted to nominate C. Frederick Yeager to receive the 1956 Citation for Outstanding Service in Employment of Physically Handicapped.

The executive secretary presented a report concerning the number of members of the Society who are not dues paying members of the American Medi-

cal Association and the subject of encouraging these members to become associated with the AMA was discussed. (AMB 9/15/55 "B"). It was agreed that this matter be presented to the county associations by the President of the Society at his visits with the county associations at their semi-annual meetings next month and that the President write a letter to each of these persons urging them to become members of the AMA.

Membership of Society.....	3,034
Membership of AMA.....	2,703
Not members of AMA.....	331

The resignation of Clifford D. Moore as chairman and member of the Committee on Mental Health was accepted with regret. It was voted that Francis J. Braceland, Hartford, be invited to become chairman of this committee and the vacancy left by Dr. Moore be not filled at this time.

State Plan for Poliomyelitis Vaccine Distribution and Use and the report of the Committee on Public Health on this subject (AMB 9/15/55 "C") were discussed at length. Dr. James C. Hart and Dr. Alexander J. Tuttle of the State Department of Health were present by invitation to explain the details of the plan. It was finally voted that the report and recommendations of the Committee on Public Health (meeting September 8, 1955) be accepted with minor amendment to the last two paragraphs containing the recommendations. These paragraphs and recommendations were amended and consolidated.

Twenty-four student members were elected. (AMB 9/15/55 "D")

It was voted that the next meeting of the Council be held on November 10, 1955, the Budget Committee to present its recommendations at that time and the Building Committee to report its progress.

The meeting adjourned at 6:45 P. M.

Meetings Held During September

- September 7—Subcommittee of Neonatal Mortality
Cancer Coordinating Committee
- September 13—Conference Committee with State Dental Association
Building Committee
Professional Policy Committee—Connecticut Medical Service
- September 14—Clinical Congress
Executive Committee—Connecticut Health League
- September 15—Clinical Congress
Council
- September 19—State Examining Board for Nurses
- September 20—Executive Committee—Connecticut Medical Service
- September 21—Committee on Neonatal Mortality
- September 22—Regional Blood Committee
- September 23—Conference with State Bar Association
- September 27—Medical Advisory Committee to Connecticut Cancer Society
Public Relations Committee
- September 28—Committee on Maternal Mortality and Morbidity
Connecticut Medical Examining Board
- September 29—Committee on American Medical Education Foundation
Subcommittee on School Health
Committee to Study Third Party Payments for Medical and Ancillary Non-Surgical Services

Student Members

David Babbott, Hartford
University of Pennsylvania—Class of 1955
Intern—Hartford Hospital—Class of 1957
Parent—Frank L. Babbott

Aldo Louis Bellucci, Hartford
University of Vermont—Class of 1954
Intern—Hartford Hospital—Class of 1956
Parent—Valentino Bellucci

David Acheson Browne, Hartford
University of Virginia—Class of 1955
Intern—Hartford Hospital—Class of 1957
Parent—Kingsbury Browne

Gerald F. Burke, Hartford
University of Minnesota—Class of 1954
Intern—Hartford Hospital—Class of 1956
Parent—Thomas Burke

Melvin H. Chalfen, Hartford
Tufts School of Medicine—Class of 1954
Intern—Hartford Hospital—Class of 1956
Parent—S. Edward Chalfen, M.D.

Walton P. C. Clason, Hartford
Harvard Medical School—Class of 1954
Intern—Hartford Hospital—Class of 1956
Parent—Freeman P. Clason

Norman L. Cobb, Hartford
University of Southern California—Class of 1952
Intern—Hartford Hospital—Class of 1957
Parent—Norman F. Cobb

William T. Goulburn, Hartford
Dartmouth Medical School—Class of 1954
Intern—Hartford Hospital—Class of 1956
Parent—Franklin P. Goulburn

James P. Johnson, Hartford
Boston University—Class of 1955
Intern—Hartford Hospital—Class of 1957
Parent—Herman Clark Johnson

Ronald P. Kaufman, Hartford
University of Pennsylvania—Class of 1955
Intern—Hartford Hospital—Class of 1957
Parent—Louis E. Kaufman

Henry B. C. Low, Hartford
St. John's University, China—Class of 1950
Intern—Hartford Hospital—Class of 1956
Parent—Dr. C. W. Low

John G. McBratney, Hartford
Western Reserve University—Class of 1952
Intern—Hartford Hospital—Class of 1956
Parent—William E. McBratney

John A. Pierce, Hartford
Duke University—Class of 1955
Intern—Hartford Hospital—Class of 1957
Parent—Ellis D. S. Pierce

Manuel Pizarro, Hartford
University of Peru—Class of 1954
Intern—Hartford Hospital—Class of 1956
Parent—Manuel Pizarro

Henry C. Rogers, Hartford
Columbia University—Class of 1955
Intern—Hartford Hospital—Class of 1957
Parent—Robert S. Rogers

John W. Schelpert, III, Hartford
Jefferson Medical College—Class of 1955
Intern—Hartford Hospital—Class of 1957
Parent—John W. Schelpert, Jr.

Christopher S. Speer, Hartford
Hahneimann Medical College—Class of 1955
Intern—Hartford Hospital—Class of 1957
Parent—Peter Speer

Harold Steinberg, Hartford
New York Medical College—Class of 1954
Intern—Hartford Hospital—Class of 1956
Parent—Michael Steinberg

Arnolfo A. Valdivia, Hartford
San Marcos University, Lima, Peru—Class of 1953
Intern—Hartford Hospital—Class of 1956
Parent—German Valdivia

William S. Vaun, Hartford
University of Pennsylvania—Class of 1955
Intern—Hartford Hospital—Class of 1957
Parent—Stratis Vounatso (deceased)

Arthur D. Wolf, Hartford
Western Reserve University—Class of 1952
Intern—Hartford Hospital—Class of 1956
Parent—Deceased

Alfred W. Wolfsohn—Hartford
University of Buffalo—Class of 1954
Intern—Hartford Hospital—Class of 1956
Parent—George Wolfsohn

Robert W. Woodhouse, Hartford
Harvard Medical School—Class of 1954
Intern—Hartford Hospital—Class of 1956
Parent—John C. Woodhouse

Max A. Zehnder, Hartford
Zurich, Switzerland—Class of 1932
Intern—Hartford Hospital—Class of 1957
Parent—Adolph Zehnder (deceased)

Special Membership Offering for Participating Physicians

In response to an increasing number of inquiries we are pleased to again offer membership in CMS to Participating Physicians and their office personnel.

The Board of Directors has authorized such memberships at the regular group rate and on a quarterly individual payment basis. The present offering will be for the Preferred Contract only. Doctors and their office personnel wishing to take advantage of it may obtain application cards by writing to or telephoning the CMS General Offices at New Haven. The cards must be completed and returned to CMS no later than October 15. Membership then will be effective December 1.

When professional services are rendered a physician or his family by a colleague an awkward situation is often created. It would be advantageous for the physician receiving services to be able to avoid the hazards of gift selection, but at the same time be assured that his associate is compensated adequately for the time spent rendering the services. CMS is obviously the mechanism by which the situation can be placed on a practical and completely ethical basis.

This matter was discussed by the Judicial Council of the American Medical Association who rendered the following decision on December 5, 1952 "that in the opinion of the Judicial Council, it was not unethical for a physician to accept payment from a prepaid insurance corporation for the professional services which he rendered a fellow physician who was so insured."

WHO MAY JOIN?

1. Participating Physicians and their immediate families (wives or husbands and all unmarried children under 19 years of age).
2. Office personnel of Participating Physicians—secretary, nurse, technician or other persons employed by the Participating Physician—and their immediate families (husbands or wives and all unmarried children under 19 years of age).

PAYMENT RATES

The group rates for the three types of membership are as follows:

Quarterly: One person \$3.60; husband and wife \$7.20; family \$10.80.

(Continued on page 834)

Special Article

FINANCIAL SUPPORT FOR OUR GROWING MEDICAL SCHOOLS

IN the college year of 1947-48 the annual operating budgets of our American medical colleges (omitting outside grants for research and any major portion of the costs of maintaining teaching hospitals) totaled a little more than \$43 million.¹ For the present year of 1954-55 this figure will have increased to more than \$93 million.² Since the end of World War II the increase of the annual operating budgets of our American medical schools has been at the average rate of \$7 million a year.

Expenditures for construction of new medical college buildings and renovation of old ones have averaged approximately \$70 million a year according to figures published in the annual reports on medical education of the Council on Medical Education and Hospitals of the American Medical Association. But in spite of the nearly \$350 million thus spent in the last five years for construction and renovation, it has been estimated that there is still need for an additional \$250 million for these purposes in the next five years.³

Few persons accuse our medical colleges of being profligate and fewer yet fail to appreciate the returns that society receives from its investment in its medical schools. The training of our physicians has greatly improved, the number of annual medical graduates has steadily increased, the research output of our schools has been prodigious and the quality of the medical service provided has made the U. S. the envy of the world.

The question must, however, be asked and answered, "Where is the money coming from to continue this important development of our medical schools?"

If the experience of the past offers any portent of the future, private donors and philanthropic foundations will continue to be important supporters of medical education. That changes in our tax structure over the past 20 years have somewhat reduced the potential of private donors cannot be denied, but the growing number and resources of our philan-

thropic foundations coupled with the humanitarian appeal of medicine augurs well for continuing support from our foundations.

It would seem natural, however, that those agencies which themselves reap the most benefit from the threefold activities of the medical schools in training physicians, carrying on research and contributing to community medical and public health services should serve as the most likely sources of financial support.

Perhaps most benefited are the cities and states in which medical schools are located. They in many instances receive preference for their sons or daughters in admission to the local school, a large part of the school's graduates are local practitioners, medical care of their indigent in the school's teaching hospital and clinic, and the services of a full range of medical specialists when needed on a consultative or referral basis. In return the state and city might well be expected to contribute generously to the construction costs and the annual operating budget of the local school and should recompense the school fairly for the medical care provided the indigent ill in the schools' teaching hospital and clinic. If every state was as generous in its support of its private medical schools as the State of Pennsylvania, and every city as willing as Los Angeles to recompense the staffs of the local schools for medical services provided the indigent, a large part of the schools' financial problem would be solved.

Perhaps next most benefited is the federal government which depends upon the 81 medical schools to supply its entire need for medical officers in the Armed Forces and Public Health Service. It is at present contributing liberally to research, very modestly to teaching in our medical schools. Most legislation so far designed to provide more substantial federal aid to medical schools has tied that aid so closely to increased enrollment that the majority of medical educators have been unable to support the legislation. Aren't the medical schools contribu-

ting sufficiently to the needs of the federal government to justify asking for moderately increased federal aid with only a minimum of incentive to enrollment and with the general assumption that each established school will take all the students it can give a good education to and will cooperate in the development of new schools as they are locally established? With six new schools in various stages of development, it seems quite unwise for the federal government to make increased aid contingent upon expansion of classes in those established schools which are already filled to the capacity of their staff and facilities.

That graduate physicians themselves have a real debt to pay to their alma mater is generally recognized. Though no one in all fairness would expect medical student fees and tuition to support the far-flung research and community service programs of the modern medical school along with its teaching program, it would seem reasonable to ask that since student tuition and fees rarely meet more than 20 per cent of the annual medical school budget, each graduate physician should be willing to contribute upon request some of his time for volunteer teaching and make an annual contribution to his alma mater or the American Medical Education Foundation. That the physicians of the country are taking this debt seriously is evidenced by the fact that in 1953, 29,132 medical alumni contributed directly to their respective medical schools \$1,089,962.93 to medical education through the American Medical Education Foundation and the National Fund for Medical Education.⁴

Also high on the list of beneficiaries of our medical schools are business and industry. Where are our corporations to look for the physicians to maintain the health, vitality and working capacity of their employees if not to the graduates of our medical schools? Where are our pharmaceutical houses to turn for their physiologists, pharmacologists, biochemists and clinical investigators if not to our medical schools? How important to our pharmaceutical houses is the basic research being conducted in the 81 medical schools of the country? There can be no doubt as to the stake that business and industry have in medical education. So clear is this relationship that the courts of at least one State have ruled⁵ that not only does the board of directors have a "valid right" to vote limited grants of corporation funds to the support of education, but they have a "solemn duty" to do so. In 1954 business corpora-

tions contributed \$1,075,326.40 to the National Fund for Medical Education.⁶

We know in general terms what the financial needs of our American medical schools are, we know what the most likely sources of that support are. If the key people in these various agencies are kept properly informed regarding medical education's growing needs isn't it likely that each agency will be willing to assume its fair share of the burden?—D.F.S.

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SPECIAL MEMBERSHIP OFFERING (*Cont.*)

EFFECTIVE DATE

All acceptable applications received by CMS on or before October 15 will have membership effective December 1, 1955. It will not be possible for CMS to consider membership applications received after October 15 for the present offering. Another offering of CMS to Participating Physicians is not planned for the near future.

COLLECTION OF PREMIUM

It is not necessary to send a premium payment with the application. The Participating Physician and each individual of his office personnel will be billed separately at their home every three months at the rates quoted above for their type of membership.

DON'T FORGET

The deadline for acceptable applications is October 15. If you want to take advantage of this offering write or telephone the CMS General Offices at your earliest opportunity.

A New Opportunity—Preventing Blindness From Retrolental Fibroplasia

Evidence from several clinical studies and from the production of the retinal lesions in at least four species of experimental animals makes it clear that uncontrolled administration of oxygen to premature babies is the major cause of the blinding eye disease, retrolental fibroplasia. Several hospitals have had no babies with permanent eye damage after instituting rigid restrictions for oxygen therapy, suggesting that blindness from this cause is entirely preventable.

Contrary to expectations, reports from Birmingham and Manchester, England; from Australia; from Montreal, Canada; Denver; Bellevue Hospital in New York; and from a cooperative study that included 18 hospitals show that limiting oxygen administration only to babies showing genuine respiratory distress, and then keeping the concentration from going higher than 40 per cent inside the incubator, does not adversely affect the survival rate.

An Arkansas State Board of Health study of oxygen administration in 24 hospitals reveals the wide variation in concentrations inside the incubator if one relies merely on prescribing oxygen by flow rate. At two liters per minute, oxygen concentrations in incubators varied from 27 to 71 per cent, at six liters per minute from 34 to 90 per cent, depending on the type of incubator and whether the vents were kept closed. The study shows that hospitals should repeatedly test oxygen concentrations inside incubators until it has been determined which rate of flow will keep the oxygen below 40 per cent for the specific incubator, and tests should be made at least once each eight hours thereafter. Physicians prescribing oxygen for prematures with definite respiratory distress will need to specify the concentration desired rather than the flow rate. In some hospitals venturimeters are being tested and other modifications are being made in an effort to obtain some type of safe, mechanical control, but these changes have not obviated the necessity for testing oxygen concentrations inside incubators.

At Bellevue Hospital, New York, this problem has been met in the premature nursery by using oxygen tanks that contain only 40 per cent oxygen and 60 per cent nitrogen. Regardless of flow rate and closed vents, it is not possible for the baby to be in an atmosphere of more than 40 per cent

oxygen. This hospital has as good a survival rate as any and has had no sight loss from retrolental fibroplasia in more than 19 months.

Because information about ways to control retrolental fibroplasia has appeared chiefly in scattered reports, several state and city departments of health have sent recommendations covering these points to pediatricians and hospital superintendents. At least one State and one large city department of health have taken additional significant steps. Whenever a member of the New York City Department of Health staff makes a routine hospital inspection and survey, a careful check-up is made of the hospital policy concerning administration of oxygen to premature infants. New York State is one of the few where there is mandatory reporting of blindness (to the Commission for the Blind in the Department of Social Welfare). As soon as blindness from retrolental fibroplasia is reported in either the city or upstate, an epidemiologic investigation will be made to determine the extent of exposure to oxygen of the reported blind baby and to explore in some detail the current practice of the hospital with regard to: (1) degree of exposure of premature infants generally to oxygen, and (2) methods used by the hospital to insure keeping oxygen concentrations below 40 per cent. Findings and recommendations following these investigations will be made available to the chief of the medical staff and the administrator of the hospital concerned.

There are some who believe that, even with the most rigid control of oxygen administration, sporadic cases of blindness from retrolental fibroplasia still might occur from other causes believed capable of producing pathologic changes in the retinal vessels of prematures. The validity of this hypothesis and the nature of other possible factors can be studied best when oxygen-induced retrolental fibroplasia has been eliminated. Since the first recognized appearance of this disease in 1941, the National Society for the Prevention of Blindness estimates that 8,000 children have lost some or all their sight from retrolental fibroplasia and that it now accounts for nearly half of all blindness in preschool children. It is hoped that every possible measure will be adopted to eliminate this cause of unnecessary blindness.

Reprinted from *American Journal of Public Health*, June, 1955.

United States Becomes "Medical Magnet"

The United States has become a "medical magnet" for physicians in Europe, Asia, Africa, and Latin America. More than 5,000 foreign physicians came to this country during the year 1954-55 for study, according to a survey by the Institute of International Education and the American Medical Association. They came from 83 different countries for internship and residency training at hospitals in 42 States, the District of Columbia, Hawaii, Puerto Rico, and the Canal Zone.

The survey of 1,177 hospitals, among those approved for internships and residencies by the AMA Council on Medical Education and Hospitals, indicated that there were at least 5,036 alien physicians in training. Not included in the study were immigrants and displaced persons.

Individual countries sending the most physicians were the Philippines, Canada, Mexico, Germany, and Turkey. Of the major geographical areas, the Middle, Near, and Far East had the largest representation.

Of the total, 620 or 12.3 per cent were women. In comparison, women made up only 5.2 to 5.7 per cent of American medical school graduating classes in the years 1952 through 1954. Over half of the women came from the Near, Far, and Middle East, with the Philippines sending the most.

More than 2,000 of the physicians were in the United States on their own resources. Others were sponsored by at least 67 different agencies, including their own or the United States government, the United Nations, and religious, educational or philanthropic organizations. Many were sponsored by the hospitals in which they were training.

In addition to the large number of physicians in hospital internship-residency training, others visited this country as observers, professors, or guest participants in research. They represented 21.5 per cent of all foreign educators who visited the country during the year.

In comparison, only 3.6 per cent of all American educators visiting other parts of the world in 1954-55 were listed under medicine.

The survey was reported in the August 13 *Journal of the American Medical Association* by Dr. James E. McCormack, associate dean of graduate studies at Columbia University College of Physicians

and Surgeons, and Arthur Feraru, head of the Central Index and Census Division, Institute of International Education, both of New York.

THE DOCTOR'S OFFICE

Donn C. Barton, M.D. announces the opening of an office for the general practice of medicine at 506 Main Street, Middletown.

Hugh J. Caven, M.D. announces the opening of an office for the practice of psychiatry at 274 Farmington Avenue, Hartford.

Michael A. Corcoran, M.D. announces the opening of an office for the general practice of medicine at 35 Riverside Road, Simsbury.

Walter E. Gustafson, M.D. announces the opening of an office for the practice of pediatrics at 715 Burnside Avenue, East Hartford.

William E. Hart, M.D. announces the opening of an office for the practice of pediatrics at 30 Sisson Avenue, Hartford.

Emilio P. Iasiello, M.D. announces the opening of an office for the general practice of medicine at 2483 Main Street, Bridgeport.

Bernard J. Kaplan, M.D. announces the opening of an office for the practice of proctology at 64 Garden Street, Hartford.

Thomas Dexter Lenci, M.D. announces the opening of an office for the practice of internal medicine at 18 Reef Road, Fairfield.

Walter S. Morgan, M.D. announces the opening of an office for the practice of internal medicine at 1876 Whitney Avenue, Hamden.

John G. O'Hurley, M.D. announces the opening of an office for the general practice of medicine at 735 B Main Street, East Hartford.

Anthony J. Pepe, M.D. announces the opening of an office for the practice of general surgery at 252 Main Street, Ansonia.

Richard C. Peterson, M.D. announces the opening of an office for the practice of pediatrics at 3589 Main Street, Stratford.

Edward J. Zebrowski, M.D. announces the opening of an office for the practice of general medicine and surgery at 7 West Main Street, Plainville.

"New Practice" Grants Offered Physicians

The Sears-Roebuck Foundation, in cooperation with the American Medical Association, has announced a new plan for assistance in establishing medical practice units with loans of up to \$25,000, beginning in 1955. The unsecured, low cost, 10 year loans will be available to physicians seeking to establish new practices but unable to arrange full local financing.

The foundation's plan is explained in detail in September 3 issue of the *Journal of the American Medical Association*.

The plan requires that the physician first exhaust all local possibilities for financing, that his application indicate a need for a practice in the proposed locality and good possibilities for success and public service, and that he give evidence of effort and thought in planning a well organized, effective practice unit. Contributions made by the grantee in repaying the grant will be turned back into the fund for the establishment of further units, thus providing what the foundation calls "built-in chain reaction." The plan also features advantages encouraging early repayment of grants to speed up establishment of more units.

The foundation states that its plan is intended to "realize the principles of opportunity, incentive, mutual help, and self reliance, to give the American people the best possible medical care, and to help the American physician build for himself the most effective, the most rewarding and the most satisfying life as a professional man." Continuation of the plan after 1955 depends on its reception and support by the medical profession. The plan relies on individual initiative and enterprise, requires that assistance be given only where it will generate independence, and is sustained entirely by those who benefit from it.

Health Insurance Survey

The ninth annual survey of health insurance in America, as of December 31, 1954, made by the Health Insurance Council, New York, shows that nearly two out of every three men, women and children in the United States now are protected by voluntary health insurance. This shows striking progress in one year.

The total of benefit payments on health insurance claims reported by the survey for 1954 exceeded \$2.7 billion, a gain of 11 per cent over the previous

year. Of the total amount, more than half went to help meet the hospitalization expenses of beneficiaries, and more than \$730 million went for surgery and medical care. Benefit payments to policyholders by insurance companies for loss of income due to disability totaled in excess of half a billion dollars last year, the survey reports.

Of the aggregate benefit payments in 1954 by all forms of voluntary health insurance, 56 per cent of the total came from the insurance companies. The dollar amount paid by the companies was over \$1.5 billion, including loss-of-income benefits.

Blue Cross and Blue Shield type plans paid more than \$1 billion, or 39 per cent of the total. Various independent plans accounted for the remaining 5 per cent of the total.

On December 31, 1954, a total of 101,493,000 Americans had hospital expense protection. This represents an increase of 4.3 per cent during that year, a rate of increase which is over 2½ times the rate of population growth in the same period. Since the beginning of 1941, the number of persons with hospital expense protection has multiplied nearly 8½ times.

Nearly 86 million persons had surgical expense protection by the end of 1954. This represents an increase of 6.1 per cent over the previous year. Ordinarily people with surgical coverage also have hospitalization protection. So, up to 85 per cent of those with hospital expense protection also had surgical coverage—up from a figure of 83 per cent one year earlier. Since 1941, the number of persons with surgical insurance has multiplied about 16 times.

Regular medical expense coverage increased by more than four million persons, or nearly 11 per cent during 1954, to give a total of more than 47 million who have this protection against the cost of nonsurgical medical care by their doctors. People with medical expense protection usually have hospital and surgical protection as well.

A total of nearly 39 million workers had protection at the close of 1954 against loss of income due to disability. This figure represents about 60 per cent of the total civilian labor force in the nation at the time.

The newest form of voluntary health insurance—major medical expense insurance—is shown by the survey to protect more than 2.2 million persons against the costs of catastrophic illness. This figure represents a gain of 83 per cent during last year.

NEWS FROM WASHINGTON

Health Legislation in Last Session of Congress

Although very little health legislation actually was enacted in the first session of the 84th Congress, a number of important bills made enough progress to insure they will get serious consideration when the second session starts next January.

Foremost is a bill to amend the social security act, and among other things provide OASI payments for disabled workers after age 50. The present provision (enacted in 1954) protects a disabled worker's pension so it is not decreased because of his years of unemployment, but payments do not begin until he reaches 65.

The new plan, sponsored by Democratic members of the House Ways and Means Committee, was rolled through the House after closed committee hearings. But when it got to the Senate, Chairman Harry Byrd of the Finance Committee held it up, saying it was too important to be reported out without the complete hearings he plans for next session.

The American Medical Association is flatly opposed to cash disability insurance. One important reason is the Association's conviction that federal machinery necessary to regulate disability examinations inevitably would project the government into the medical care field. There are many other reasons, including the relationship between cash payments for disability and the patient's interest in rehabilitation. The issue of disability pensions will be settled next year in the Byrd Committee or on the Senate floor.

A bill for \$90 million in grants for building and equipping nonfederal research facilities passed the Senate, and is awaiting action in the House Interstate and Foreign Commerce Committee. Hearings have been held on a bill for U. S. grants to medical schools and on another (Jenkins-Keogh) to allow self-employed persons to defer income tax payments on part of their income put into annuities.

Other bills that will be ready for action in January include legislation to stimulate nursing education, improve the medical care of military dependents, authorize health insurance for government

workers, authorize U. S. guarantee of mortgages on health facilities, and offer military medical scholarships. The administration's bill for reinsuring health insurance plans by now is a little shopworn, but it still might be pushed again next year.

President Eisenhower has made it known he wants Congress to get to work on health legislation early next session. His urging might not be needed. Next year is a presidential election year, and both parties will exert themselves to enact, and take credit for, new health programs that carry public appeal.

Despite the hundreds of hours of hearings in Senate and House, not a single important permanent medical program was set up by Congress in the last session. A national mental health survey, supported by the AMA, was enacted, but the administration's plan for mental health grants will be up for action next year.

Ignoring protests of physicians and dentists, Congress extended the doctor draft act for another two years, after first adopting two amendments. It exempted all men over 45, and all 35 or older who previously had been rejected for medical commissions for physical reasons alone.

For almost four months Congressional committees pondered what to do about Salk poliomyelitis vaccine. At first there were two main questions: 1. How much money should Congress spend to buy vaccine for free shots, and who should get them? 2. How far should the federal government move into the picture to insure equitable allocation?

One of the proposals—this even got through the Senate—was to offer unlimited money to the States, which in turn could give free shots to any persons or group of persons under age 20. President Eisenhower's idea—which he urged on Congress several times—was simply to insure that no person in need of the vaccine would go without it for financial reasons. Eventually his view prevailed and the States now are drawing on a \$30 million fund. This law expires next February 15.

As weeks passed, there was less and less enthusiasm for setting up a federal allocation system, which Secretary Hobby and Surgeon General Scheele repeatedly told Congress was not needed. Consequent-

ly, when the National Foundation announced it had all the vaccine it needed for its program, a voluntary allocation plan was put in effect. The plan has the support and cooperation of physicians, pharmacists, drug manufacturers, and the state health officers. The Department of Health, Education, and Welfare is the liaison between the pharmaceutical houses and the States, dividing the vaccine on the basis of the number of unvaccinated persons in the eligible age groups.

Revenue Bureau Summarizes Medical Expenses Under Tax Law

Deductible and nondeductible medical expenses for income tax purposes have been summarized by the Bureau of Internal Revenue in a series of rulings that combine new interpretations with a clarification of old rulings. Some examples:

Travel expenses to and from a location where daily visits to a medical clinic are required are deductible but (since 1954) cost of food and lodging are not, except as part of a hospital bill. *On education and training*, special instruction in speech and lip reading for a deaf child are deductible expenses, but not a course of ordinary instruction. Psychiatric care and therapy at specially equipped treatment schools for alleviating mental illness are deductible items, but where cost of instruction at a psychiatric school does not represent medical care, it is not deductible. *On health and accident indemnity insurance*, if a policy covers both injury indemnity and medical expense reimbursement, premium cost for latter is deductible but not for former. *On other points*, ordinary exercise rubdown, air conditioner, oxygen equipment, iron lung, special bed board, all are deductible items when prescribed by a physician for an illness, but not food for ulcer patient, maternity clothing, diaper service, wigs or toothpaste.

Federal Medical Research Study Planned by NSF

An extensive review and evaluation of all medical research programs of the Department of Health, Education, and Welfare will be undertaken by a special committee named by the National Science Foundation. Requested by HEW, the project will consider the following: (1) rate of growth of National Institutes of Health and other research

unit programs in light of federal responsibilities in this field, (2) proper balance of effort between basic research and research aimed at prevention, diagnosis, care and cure of diseases, and (3) relative distribution of research effort among major special fields of health. Federal spending for medical research has grown steadily since the creation of the National Institutes of Health in 1948. That year the annual appropriation amounted to approximately \$30 million. For the institutes' many programs this year, Congress recently appropriated \$97,573,000. Dr. C. N. H. Long, Yale University School of Medicine is chairman and Dr. Joseph Pisani, University College of Medicine at New York City, executive secretary. The study committee hopes to make its first preliminary report in November.

Civil Service Increases Pay Scales for Government Doctors

In a move to step up the recruitment of 1,123 civilian physicians for assignments in federal posts (Defense, Veterans Administration and Public Health Service), for the next year the Civil Service Commission has authorized their employment at the top salary of each grade. This raises beginning salaries from \$7,465 to \$12,690 a year as against \$6,390 to \$11,610. The commission said the Defense Department alone hoped to recruit 855 physicians during the next 12 months. The Army noted, for instance, that while increasing numbers of civilian doctors are being employed in Army medical facilities, openings exist "in practically every locality." Physicians interested in applying should contact their closest military installation.

New House Legislation

HR7036—Tax Code Conformed to Liberalized Social Security Amendments. (Mason, R—Illinois, June 27.) Would amend 1954 Internal Revenue Code to make its provisions restricting retirement income tax credit conform to the corresponding liberalized provisions of the social security amendments of 1954. Under the new Social Security Amendments earned income to be excluded, in determining whether social security benefits were to be reduced, was raised last year from \$900 to \$1,200. The work test was made applicable to those aged 72 and over, rather than to those aged 75 and over. Section 37 of the 1954 Revenue Code grants

an individual who is 65 years or over a credit against his tax liability equivalent to the tax, at the first bracket rate, (20 per cent for 1954) on the amount of retirement income up to \$1,200. This proposed legislation, of interest to many physicians, would increase from \$900 to \$1,200 for employees and the self employed the amount that an individual can earn without reducing the \$1,200 on which the retirement credit is compiled. Since social security benefits presently are not available to those under 65, this bill would raise the earnings tests from \$900 to \$1,200 only for those aged 65 to 72. Estimated revenue reduction would be \$11 million annually. Ways and Means.

HR7846—Federal Scholarship Act. (Multer, D—New York, August 2.) Would authorize loans to enable needy and scholastically qualified students to continue post-high school education, including premedical, with a \$5 million federal fund the first year, and \$10 million the second.

State contribution to the fund each year would be 5 per cent of loan advances; in event fund is not self sustaining, State contribution could go to 10 per cent. Treasury's decision whether the fund is self sustaining would be final. State allocation would be in proportion to its number of Representatives in Congress. Students would not be eligible to borrow unless State by legislative enactment has accepted program, including agreement not to discriminate on account of race, creed, color, or national origin. State would have to enact legislation removing incapacity to contract (at time of borrowing) as a defense in any action to collect amount payable to U. S. State agency would certify list of students eligible but Federal Commissioner of Education would select students, and Secretary of Treasury would execute contract with student and make advances. To be eligible, student must be "financially unable to continue posthigh school education" and not be eligible for any GI educational benefits.

Loan provisions: first four years, not to exceed \$1,000 per year with not more than \$750 in excess of tuition; first four postcollege graduate years, not to exceed \$1,500 with not more than \$1,000 in excess of tuition. Loans would be authorized and repaid over ten years beginning second year after borrowing ceases, with interest at 1 per cent per year. In eleventh year borrower would pay Secretary of Treasury 10 per cent of amount borrowed. All

amounts borrowed and loan conditions must be evidenced by a note, cosigned by parents or by legal guardian unless waived by Commissioner of Education. If not paid according to terms, suit could be brought on note. Education and Labor.

Hoover Recommendations

The fact that neither Congress nor the White House took action in 1955 to implement any of the Hoover Commission's recommendations dealing with government's vast medical establishment is no guaranty that it will continue looking the other way next year. Bills are pending in both House and Senate to abolish Public Health Service hospitals, sharply curtail veterans' health care, transfer Armed Forces Medical Library to civilian control and set up a Federal Advisory Health Council—all highly controversial.

Another special report of 1955, that of the Commission on Intergovernmental Relations, also may exert a measure of influence upon future health legislation. The same may be said of narcotics investigation currently being conducted by a Senate committee headed by Senator Price Daniel (D—Texas).

Two VA Medical Advisory Councils Consolidated

Veterans Administration has merged its two medical advisory boards. For nearly 10 years, or ever since reorganization of VA's Department of Medicine and Surgery, there were two such units—the Special Medical Advisory Group, serving the VA Administrator and created by law, and Council of Chief Consultants, serving the chief medical director but lacking statutory status. Overlapping of function was recognized several years ago, resulting in coordinative reforms, and now the council has been absorbed by SMAG. Dr. Wendell G. Scott continues as its chairman.

With membership expanded to 23, SMAG has been joined by Drs. C. L. Brown (education), Donald A. Covalt (physical medicine), Howard K. Gray (surgery), Donald S. King (tuberculosis), Clarence S. Livingood (dermatology), and Albert M. Snell (gastroenterology). All six formerly were members of Council of Chief Consultants. Others who served on CCC will continue as consultants to VA in their various specialties.

Advisors to Red Cross

American Red Cross has formed a medical advisory committee. First aid, disaster relief, nursing and other ARC activities having medical aspects (except for the blood program, which has its own group of consultants) will come within new group's range of operation. Members: Drs. George M. Wheatley, William D. Stovall, Ross T. McIntire, I. S. Ravdin, John S. Lundy, James R. Reuling, Maxwell M. Wintrobe, R. Lee Clark, Jr., and Frank W. Konzelmann.

\$35.8 Million Research Grants Approved by NIH

Public Health Service has approved awards of medical research grants totaling \$35,780,778, probably the largest sum ever announced at one time for this purpose. The awards, made to hundreds of investigators in scores of teaching institutions, hospitals, clinics and research laboratories, were recommended by the eight advisory councils to National Institutes of Health. Total represents more than 90 per cent of the \$38.5 million appropriated by Congress for support of non-Federal medical research in 1955-56. Approximately \$25.4 million in awards go for projects which had received previous NIH support and where there were continuation commitments. Remainder is for new projects, together with existing ones which had to compete with the former for funds.

Cutter Free to Submit Salk Vaccine for PHS Clearance

The issuance August 25 of the Public Health Service's four-month study of poliomyelitis vaccine produced by Cutter Laboratories has cleared the way for the firm to submit newly produced vaccine for approval. Surgeon General Scheele said if the vaccine meets all revised production and safety testing standards, then vaccine will be released. PHS in April asked Cutter to halt distribution when the first cases of polio were reported among children who had received injections of vaccine made by Cutter. PHS in its August 25 report made these points:

1. While exact reasons for the presence of infective amounts of live virus in some lots of Cutter vaccine could not be found, study of the laboratories' data against the general experience of the in-

dustry during the same period, "strengthens the probability that the cause of the trouble was inadequate inactivation coupled with failure of the safety tests to demonstrate the presence of virus."

2. Equipment, physical arrangements and routine handling at Cutter were checked in detail and "nothing was found to indicate that the infective amounts of live virus were attributable to contamination."

3. Prior to May 27 when PHS issued revised minimum safety standards for the vaccine, the inadequacy of inactivation was "not unusual," and there were "then fundamental weaknesses in the safety testing procedures which failed to assure what is now believed to be a satisfactory degree of sensitivity."

Resolutions for AMA House of Delegates

Should any of our readers wish to submit a resolution for introduction into any session of the AMA House of Delegates, it is urged that such resolutions be submitted to the secretary's office in Chicago at least 30 days in advance of the meeting. By so doing it will be possible to have mimeographed copies of all resolutions completed in advance of the session and avoid placing an almost impossible burden on the staff at the place of the meeting.

At the last session in Atlantic City 55 resolutions were handed in at the secretary's office in Atlantic City and only 29 in Chicago. This meant working through the night to prepare the necessary copies before the opening session of the House of Delegates.

O.A.S.I. Poll

The Board of Governors of the Connecticut State Dental Association has voted to poll the membership on the question of dentists being included under Old Age and Survivors Insurance. Factual information as to the benefits, and objections to O.A.S.I. will be mailed with the questionnaire card. It is hoped to get this in the mail the first part of August, and to have all returns in before September 1. It is hoped to have nearly a 100 per cent return, so that the results will represent the wishes of the entire membership, not just a small part. Life members, all of whom are over sixty-five, are not included in this poll.

GOALS FOR MEDICAL EDUCATION

The goal of the American Medical Education Foundation's 1955 campaign is two million dollars.

The National Fund for Medical Education plans to raise eight million dollars for our medical schools from industry and other corporate groups.

Medical education is being more widely supported than ever before—and the leadership of physicians is vitally needed to maintain this interest. If you haven't contributed to the 1955 campaign, you may obtain a contribution card by using the coupon on this page.

**Medical Education
Needs Your Help**

Connecticut State Medical Society
160 St. Ronan Street
New Haven 11, Connecticut

Please send a contribution card and information concerning the American Medical Education Foundation.

Name

Office Address.....

.....

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington <i>Chairman</i>	Morris A. Hankin, New Haven D. Olan Meeker, Riverside	James H. Root, Jr., Waterbury Alfred J. Sette, Stamford
Harold A. Bergendahl, Norwich James C. Canniff, Torrington	Harry C. Knight, Middletown Stewart P. Seigle, Hartford	William A. Richardson, Noroton <i>Associate Member</i>

Five National Medical Television Series

Announced for New Season

Five regularly scheduled medical TV programs have been announced for the 1955-1956 season by the national networks. These programs will be presented to a combined potential audience of 75,000,000 people each week.

Motion picture producers report that several medical programs are to be filmed for use by commercial sponsors on local stations. In addition to the medical presentations, a recent survey by the American Medical Association indicates that ten State medical societies and ninety-nine county medical associations are conducting television programs or are planning to do so.

A noteworthy development in the Connecticut TV picture this year will be the telecasting of "Medic" three Mondays out of four at 9 P. M. over the facilities of WKNB-TV, New Britain. The series began September 5, marking the first time the program has been telecast by a Connecticut TV station. It is anticipated that this will materially increase the audience and that more mail will be received by the NBC offices. These letters are forwarded to the Los Angeles County Medical Association, sponsoring organization, and then are forwarded to the respective State and county medical associations for reply.

"Medical Horizons," a new series to be presented over the ABC-TV network in cooperation with the American Medical Association, will be telecast by three Connecticut stations, WNHC-TV, Channel 8; KGTAH-TV, Hartford and WATP-TV, Waterbury. The series began September 12, but will not be telecast by WNHC-TV until October 3 because of previous commitments. The program is scheduled for each Monday at 9 P. M.

The popular "March of Medicine" series is again scheduled for the NBC-TV network, and the first program will be telecast September 20, 9:30 P. M.

The increase in medical television programs reflects the rapid expansion of the medium as a major channel of public communication. During the first six months of this year, more than 2,500,000 new television sets were placed in homes throughout the country. This increases the estimated number of sets in the United States to 36,500,000. There are now 406 TV stations operating in 253 cities and many more are awaiting licensure by the Federal Communications Commission.

The following list presents the most complete information currently available concerning medical telecasts for the 1955-1956 season:

- A. SCHEDULED PROGRAMS
1. "Medic," New Britain, Connecticut, WKNB-TV, 9 P. M. Eastern Time. Three Mondays out of four.

2. "March of Medicine," New York City, N. Y., WRCA-TV, 9:30 P. M. Eastern Time. Every month. Schedule: September 20—"Report on Cancer;" first week in November; first week in December—coverage of scientific presentations at AMA's Clinical Session in Boston.

3. "Medical Horizons," New Haven, Connecticut, WNHC-TV, 9:30 P. M. Eastern Time. Every Monday night starting in October, 1955. Featuring pickups from medical schools and research institutions. Schedule: September 19—"Preception and Personality Study" from University of New York College of Medicine; September 26—"Rehabilitation, a Total Approach," from Kessler Institute, West Orange, N. J.; October 3—"The Physiological Emergency Team," from Sloan-Kettering Institute Memorial Center for Cancer and Allied Diseases, N. Y.; October 10—"Mechanical Filter for the Kidney," from Georgetown University Medical School; October 17—"The Training of a Medical Student," from University of Pennsylvania School of Medicine; October 24—"Residency Training Program," from Johns Hopkins Hospital, Baltimore.

B. OTHER PROGRAMS ANNOUNCED, BUT NOT YET

ASSIGNED STATION SCHEDULES

1. "Dr. Spock," NBC-TV, 3:00 P. M. Eastern Time. First program Sunday, October 9, 1955—one-half hour. Featuring Dr. Benjamin Spock, covering questions dealing with child rearing from medical and psychological viewpoints.

2. "Medical and Health News with Howard Whitman," NBC-TV. Every Wednesday morning, ten minutes. Featuring new medical information.

C. FILMED PROGRAMS

1. "Dr. Hudson's Secret Journal." Written by Lloyd C. Douglas. Starring actor, John Howard. Consisting of 39 half hour programs.

2. "It's Fun to Reduce." Produced by Guild Films. Programs dealing with problems of overweight.

New AMA Booklet for Physicians' Offices

A new booklet entitled "To All My Patients" will be mailed to all physicians in October.

The 12-page pamphlet has been planned for distribution through physicians' offices and explains the role of the physician and the medical team. The booklet also briefly discusses medical and hospital fees and the advantages of voluntary health insurance. Designed to promote physician-patient relationships, the booklet provides space for recording the physician's name, address and office hours.

Following the October mailing, quantities of the booklet may be obtained through the office of the State Medical Society.

Newspaper for Physicians

The first issue of *Medical News*, a newspaper for physicians, was published September 12. It is planned to publish the newspaper every other Monday according to the sponsors, Ciba Pharmaceutical, Inc.

The first issue comprised 8 pages in a tabloid format and included a variety of stories on the activities of physicians and the progress of medical science.

More Health Tips for Television Audiences

The third in a series of five-minute films entitled "What To Do" has been made available by the American Medical Association for local medical

associations interested in advancing educational television. The film stresses the importance of proper care for a patient while awaiting the arrival of the physician. Featuring Abby Lewis, radio and television character actress, the series also presents authentic information on the following subjects: eye injury, back ache, dizziness, hay fever and skin problems.

New AMA Pamphlet Coming on Social Security

A new pamphlet, covering all aspects of social security as it pertains to the federal proposal to establish a national system of cash benefits for persons who are totally and permanently disabled, has been prepared by the AMA public relations department and will be ready for distribution within a few weeks.

The pamphlet leads off with an article, "Compulsory Cash Disability Benefits—the Legislative Blitz," which appeared on page 1442 of the August 20 issue of the *AMA Journal*.

Other articles are:

"The Outlook for Social Security," by A. L. Kirkpatrick from the October-November issue, *American Economic Security*, published by the Chamber of Commerce of the United States.

"Total Disability Should Be Covered by State Assistance Programs Aided by Federal Grants and Not By Inclusion in a Federal Contributory Social Security Program," distributed by M. A. Linton, Chairman of the Board, Provident Mutual Life Insurance Company of Philadelphia.

"Providing for Those in Need," by Philip H. Vogt, from the May-June issue, *American Economic Security*.

"Paying for Economic Security—Through Voluntary Individual Action," by Powell B. McHaney, from the May-June issue of *American Economic Security*.

"Trends in Social Security," a series of tables and charts by Fred D. Lindsey, Economic Research Department, Chamber of Commerce of the United States.

A statement by Oveta Culp Hobby based on her testimony before the Senate Committee on Finance, July 26, 1955.

FROM OUR EXCHANGES

Isotopes can be used in clinical research in two principal ways: first, to simplify existing analytic or diagnostic methods; and second, to study phenomena that cannot be examined readily, if at all, by conventional biochemical methods. (Clinical Research Using Compounds Labeled with Radioactive Carbon and Hydrogen as Tracers, Leroy, *Ann. Int. Med.*, 42:2, pps. 239-249.)

Articles dealing with material of this nature are beginning to appear commonly in the medical journals across the nation. Practically all the articles have one thing in common and that is that they present a forbidding aspect to the clinician because of the mathematics involved. Arithmetic and logarithms cannot be avoided if we are dealing with isotopes but we can urge that the mathematical aspects and the concepts they describe be explained in relatively simple terms. In any event we must make the effort to understand the concepts for as time goes on they will form the basis of much important contemporary clinical research.

LeRoy's article has the virtue of being nearly understandable to at least one reader. It is clearly obvious that experiments in which the radioisotopes of carbon and hydrogen are used can be designed to explore virtually any aspect of biochemical dynamics. The author asserts that the investigators who are using isotopes to explore and explain metabolic processes in man are revolutionizing our knowledge and rewriting our textbooks. "It is necessary that we appreciate what they are doing."

Crozier and Ainsley present evidence in favor of the proposition that the Guillain-Barré syndrome is an allergic phenomenon. They outline in some detail the differential diagnosis between the Guillain-Barré syndrome and poliomyelitis. (*New Eng. Jour. Med.*, 252:3, pp. 83-88.) The authors have found that the most valuable therapeutic agents at present are cortisone and ACTH. Treatment should be instituted early in the course of the disease and should be prolonged to avoid relapse.

Plastic Planing of Acne Scars (Other Skin Defects) is considered by Reiches and Eskeles to be a

distinct advance, both in method and results, over most other technics for treating scars from acne and other skin defects (*Missouri Med.*, 52:3, pp. 192-193). The author used a Kurtin Plastic Planer which is a fine steel brush. The steel wire is slightly curved in the direction of rotation. The electric motor rotates 12,000 times per minute. Cold packs are applied to the face plus the use of ethyl chloride anesthesia. After a proper interval the scarred areas are planed. The afterdressing used by the authors was spectrocin or erythromycin. The patients, even when large areas were treated, were able to return to their normal duties within a few days. In simpler cases patients often resumed their regular round of activity after 24 hours.

The authors regard plastic planing as an office dermatologic treatment. The whole procedure sounds simple and easy but it is probably wise to leave it in the hands of men of experience. We are allowed to suspect that the method has some "bugs" that makes caution the part of wisdom.

Pitfalls in the Diagnosis of Pernicious Anemia is a timely discussion of factors that lead to delayed diagnosis and improper treatment of the disease. Oddly enough the clarification of the mechanism of pernicious anemia has been a major cause of these errors (*Conley, G. P.*, XI:1, pp. 59-61).

In the author's opinion pernicious anemia results from a deficiency of vitamin B₁₂. The characteristic hematologic, gastrointestinal, and neurologic manifestations lead physicians to empirically prescribe multivitamin preparations. If the preparation contains folic acid some of the symptoms disappear. However, the neurologic disorders are not affected and may progress to a crippling effect.

No treatment of pernicious anemia is superior to the regular parental administration of vitamin B₁₂, or refined liver extract. Preparations designed for oral use are for the most part inadequate and are still in the experimental stage of study. They cannot be recommended for general use in pernicious anemia.

Since the introduction of folic acid nearly half the cases of pernicious anemia admitted to Johns Hopkins Hospital arrive with neurologic disease in

the absence of appreciable degree of anemia. Folic acid deficiency in the United States is rare, and the indiscriminate use of this vitamin is not justified. "Under no circumstances should folic acid in any form be administered to a patient whose symptoms might be those of pernicious anemia" until a diagnosis has been established and then only for a defined purpose. A most valuable diagnostic test available in dealing with anemia is the response to specific therapy. There is a dramatic response in pernicious anemia to the injection of vitamin 12. This test is of no value if "shot-gun" preparations have been previously used.

* * * *

The broncho-thymic syndrome is a controversial subject among pediatricians. Larson concludes (*Dak. Jour. of Med. and Pharmacy*, VII:1, pp. 1-2) (1) that enlargement of the thymus gland has no clinical significance in the vast majority of infants having respiratory symptoms; (2) the review of the histories of over one thousand infant patients treated by irradiation reveals striking clinical improvement of respiratory symptoms in most of them; and (3) it is believed that the relief of symptoms is effected by the rapid response of pulmonary lymphatic structures to irradiation.

There can be no argument on the fact that many infants with respiratory symptoms are promptly and spectacularly improved by irradiation.

* * * *

Pommerenke was recently assigned as visiting professor to the Keio Gijuku University School of Medicine, Tokyo under the Unitarian Service Committee. In his General Report is included a chapter on Abortions in Japan which he reprints in *Obstetrical and Gynecological Survey* (10:2, April 1955, pp. 145-175). It furnishes some illuminating facts as well as much food for thought.

The Public Health Administration of Japan reported induced abortions in 1953 numbered 103,538. The Children's Bureau of the University of Health and Welfare gives a figure of 805,524 abortions in 1952. Pommerenke believes the true number of abortions must greatly exceed the published figures. "So liberally are the indications for an abortion opera-

tion interpreted that the mere assertion that economic stringency in the family exists, and that this is unharmonious with the interests of good health, is justification enough."

Japan has a population dilemma but its method of dealing with it has no counterpart in the world today. The incidence of abortions is very apparently on the increase. The worst part of the story is found in the actual conditions under which these abortions are performed and the complications which follow. The operators never wear cap, mask or gloves and in the so-called clinics where abortions are performed the technic was described as outrageous and there appeared to be little regard for blood loss or the patient's protestations of pain.

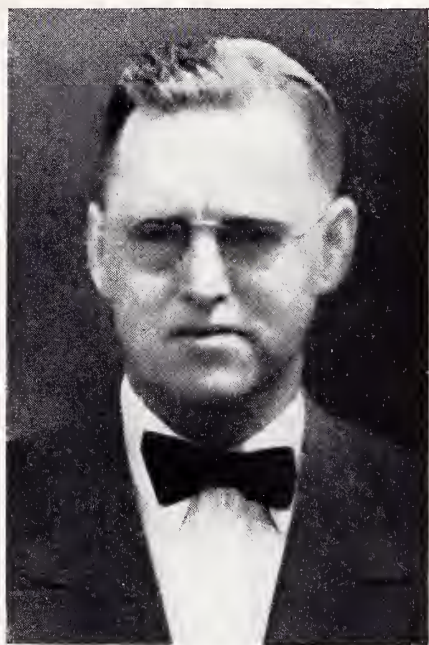
Abortions have cut down Japan's birth rate from 29.4 to 23.3 in 12 years, but at what price? Not enough time has elapsed to furnish a thorough appraisal of the abortion practice. Several reports of complications of abortions have been published, but these may not be strictly reliable as to detail. Women have died following dilatation and curettage, some as late as the seventh month. Many more died following the injection of salt solution into the uterus. Others died following a variety of procedures used to produce an abortion. Hemorrhage and infection played a prominent part. The gynecologist, in the opinion of Pommerenke, will regard the prevailing practice as an unmitigated evil.

* * * *

The Changing Number and Distribution of the Aged Population is the subject of an interesting discussion by Smith (*Jour. Amer. Geriatrics Soc.*, III:1, pp. 1-14). Our population is aging rapidly. During the last half century the number of people of 65 and over has increased 300 per cent as against 100 per cent for the rest of the population. It is estimated that this group will total about sixteen million by 1960; and their numbers will continue to rise until about 1990. A surprising conclusion is that immigration accounts for about 23 per cent of the increase, and that improved expectation of life or the reduction of mortality rates for approximately 20 per cent. The remainder of the increase seems to be due to a growing birth rate.

OBITUARY

Maurice L. Cheney, M.D. 1894 - 1954



Maurice L. Cheney died suddenly December 3, 1954 of coronary thrombosis at his home in Fairfield, Connecticut. Dr. Cheney was born in Lyndonville, Vermont in 1894, the son of Ida Lyon and Albertus Allen Cheney. His father practiced medicine in Lyndonville for more than fifty years till his death at 79 in 1943. Maurice attended Norwich University where he was on the football team.

After graduating cum laude from the University of Vermont Medical School in 1917, he began his internship at the Bridgeport Hospital but left after a short period to serve as a lieutenant in the Medical Corps with the A.E.F. in France. Returning to Bridgeport in 1919, he was appointed on the surgical service of Dr. Phillip Bill and Dr. John Shea, both of whom were known in the community as surgeons of outstanding ability.

Dr. Cheney qualified by examination for certification by the American Board of Surgery in 1941, the first surgeon to be so qualified in Bridgeport. On the reorganization of the staff in 1946 he was named the

first chief of surgery in the modern history of the Bridgeport Hospital. Upon his retirement at the end of thirty-five years of active service he was guest of honor at a dinner of the surgical group and presented with an engraved watch, an expression of the affection of his associates for this sturdy and kindly man.

He is survived by his wife, Mrs. Wanda Cheney, two brothers, Paul and Jack D., and four children, Mrs. Phillip G. Hackwell, Lionel, Pamela and Maurice A. Cheney.

The worth of a man is often obscured in the routine of life's daily rounds, and his qualities unperceived when we are absorbed in our own preoccupations. Maurice Cheney's surgery was done neatly, with dispatch, and when necessary. Innumerable citizens of the community benefited from his conscientious care. He was disciplined, neither chary nor prodigal of friendship, and deeply loyal to his friends and to the right, as God gave him to see the right. He was devoted to his family.

His dignity and self sufficiency as well as his speech were racy of his native Vermont. During his vacations at his farm in Guilford he was completely happy, renewing friendships and breathing the air of his native State, every rock and rill of which he loved unblushingly. He often quoted the following lines of his favorite author, Rudyard Kipling, lines he said were undoubtedly written with Vermont in mind:

"God gave all men all earth to love,
But since our hearts are small
Ordained for each one spot should prove
Beloved over all."

Dr. Cheney lived through a period when, it seems to many, the profession of medicine gradually lost some of its dignity and personal quality. Yet he remained definitely an upholder of the old traditions. Now that his life is rounded out and ended, to have known that he would be remembered as a man of integrity and a worthy physician would have fulfilled his boyhood dreams.

David T. Monahan, M.D.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Norman J. Barker, Collinsville

President-Elect, Mrs. E. Roland Hill, Mystic

First Vice-President, Mrs. Charles Murray Gratz, Cos Cob

Second Vice-President, Mrs. Morton Arnold, Windham Center

Recording Secretary, Mrs. Charles Culotta, Hamden

Corresponding Secretary, Mrs. James E. Stretch, Simsbury

Treasurer, Mrs. Joseph Cutler Woodward, South Lyme

The September issue of *Today's Health* carries two pages of pictures and copy on the annual meeting of the American Medical Association. One picture shows Mrs. George Turner presenting a check of \$80,000 to Dr. George F. Lull as the Woman's Auxiliary contribution to the American Medical Education Foundation.

County News

NEW LONDON

Mrs. William J. Murray, Jr., as chairman of Public Relations, manned a health display booth at the Hamburg Fair in August. A second exhibit was planned for the Norwich Grange Fair in September.

The Nurses Scholarship and Welfare Bridge and Cake Sale was held on October 4 at the Lighthouse Inn in New London. The cochairmen for this event were Mrs. Joseph Murray and Mrs. Frederick Fagan.

On October 18 the semi-annual luncheon meeting will be held at Lighthouse Inn.

MIDDLESEX

The Woman's Auxiliary to the Middlesex County Medical Association was saddened by the passing of its loyal and devoted charter member, Mrs. Charles B. Chedel, this summer. Even though Mrs. Chedel left Middletown several years ago to reside in Spokane, Washington with her daughter and son-in-law, Dr. and Mrs. Richard Miller, she kept her membership in the Auxiliary.

Mrs. Chedel will be remembered for her interest in the civic and social life of Middletown as a member of the Middletown District Nurse Association, Board of Directors; the Board of Directors, St. Luke's Home; the first Middlesex Hospital Auxiliary; the Holy Trinity Church.

Dr. Chedel passed away in 1933 and the Middlesex County Auxiliary considers it a tribute to the County Medical Association and the Auxiliary to

have a member who maintained her interest and devotion despite her widowhood and her removal to another State.

During the month of August the Auxiliary manned health booths at two fairs: Durham 4-H Fair, Mrs. Louis LaBella, Mrs. Harold Smith and Mrs. Mark Thunim; Chester Fair, Mrs. Joseph Epstein.

LITCHFIELD

All Auxiliary members have been affected by the flood. The Torrington doctors set up a Medical Emergency Service in Charlotte Hungerford Hospital and in Torrington School. Doctors in most of the towns set up First Aid stations and clinics for administration of typhoid inoculations. Mrs. Winfield Wight, Auxiliary president, wishes to extend sympathy on behalf of the entire membership to the doctors whose offices were flooded and to the members whose homes were flooded.

Due to the flood, all the fairs in Litchfield County have been cancelled.

Dr. Buie Named Air Force Consultant

Dr. Louis A. Buie, senior consultant in the Section of Proctology of the Mayo Clinic, has been appointed a national consultant to the Surgeon General of the U. S. Air Force for a one year period which terminates on June 30, 1956.

Dr. Buie, who is a member of the AMA House of Delegates, a member of the AMA Judicial Council, and chairman of the AMA Council on Constitution and By-laws, will visit various medical treatment centers maintained by the Air Force. Surgeon General Dan C. Ogle said that Dr. Buie was selected because of "the fine judgment he has demonstrated in medical affairs through the years."

PRO-BANTHINE® FOR ANTICHOLINERGIC ACTION

A Combined Neuro-Effector and Ganglion Inhibitor

Pro-Banthine consistently controls gastrointestinal hypermotility and spasm and the attendant symptoms.

Pro-Banthine is an improved anticholinergic compound. Its unique pharmacologic properties are a decided advance in the control of the most common symptoms of smooth muscle spasm in all segments of the gastrointestinal tract.

By controlling excess motility of the gastrointestinal tract, Pro-Banthine has found wide use¹ in the treatment of peptic ulcer, functional diarrheas, regional enteritis and ulcerative colitis. It

is also valuable in the treatment of pylorospasm and spasm of the sphincter of Oddi.

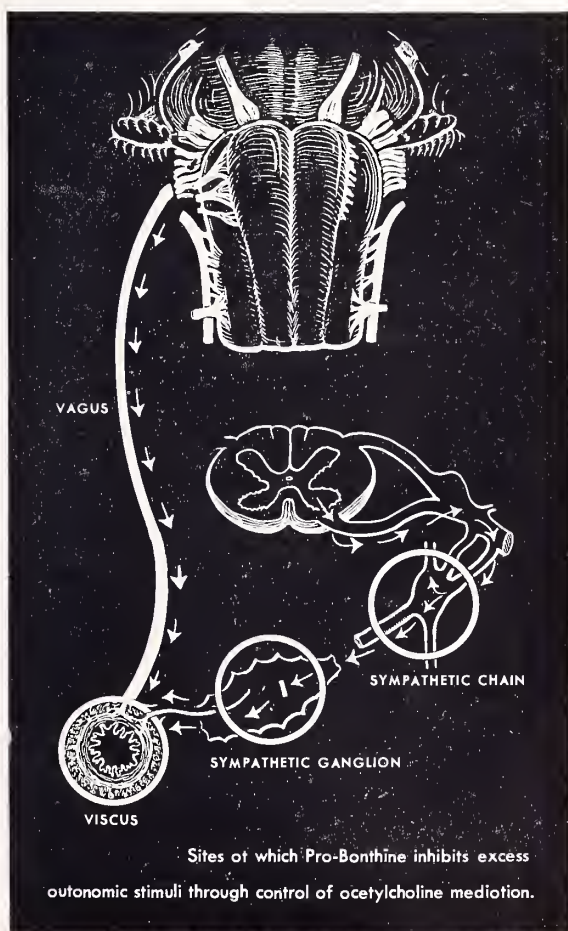
Roback and Beal² found that Pro-Banthine orally was an "inhibitor of spontaneous and histamine-stimulated gastric secretion" which "resulted in marked and prolonged inhibition of the motility of the stomach, jejunum, and colon. . ."

Therapy with Pro-Banthine is remarkably free from reactions associated with parasympathetic inhibition. Dryness of the mouth and blurred vision are much less common with Pro-Banthine than with other potent anticholinergic agents.

In Roback and Beal's² series "Side effects were almost entirely absent in single doses of 30 or 40 mg. . ."

Pro-Banthine (β -diisopropylaminoethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) is available in three dosage forms: sugar-coated tablets of 15 mg.; sugar-coated tablets of 15 mg. of Pro-Banthine with 15 mg. of phenobarbital, for use when anxiety and tension are complicating factors; ampuls of 30 mg., for more rapid effects and in instances when oral medication is impractical or impossible.

For the average patient one tablet of Pro-Banthine (15 mg.) with each meal and two tablets (30 mg.) at bedtime will be adequate. G. D. Searle & Co., Research in the Service of Medicine.



1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: *Gastroenterology* 25:416 (Nov.) 1953.
2. Roback, R. A., and Beal, J. M.: *Gastroenterology* 25:24 (Sept.) 1953.

SEARLE

SPECIAL NOTICES

THE CONNECTICUT ACADEMY OF GENERAL PRACTICE ANNOUNCES THEIR FIFTH ANNUAL SCIENTIFIC ASSEMBLY

Hotel Statler, Hartford, Connecticut

Thursday, October 20, 1955

Morning Session: Capitol Ballroom

Moderator: William Lahey, M.D., director of Medical Education at Saint Francis Hospital, Hartford, Connecticut.

9:00-10:00

Registration

10:00-10:40

Recent advances in the treatment of skin eruptions

Harry M. Robinson, Jr., M.D. professor of Dermatology, University of Maryland School of Medicine, Baltimore, Maryland

10:40-11:20

Recent developments in the management of hypertension

Robert L. Parker, M.D. associate professor of Internal Medicine, University of Minnesota School of Medicine, Minneapolis, Minnesota

11:20-12:00

Radioactive isotopes in diagnosis and treatment

J. W. Howland, M.D. professor of Radiation Biology, University of Rochester School of Medicine, Rochester, New York

12:00-12:30

Questions and panel discussion

12:45-2:15

Luncheon for doctors and wives—Terrace Room

Chairman: Peter J. Scafarello, M.D. secretary, Connecticut Academy of General Practice

Speaker: Leonard E. Read, Foundation for Economic Education, Irvington-on-Hudson, New York

"Have we solved the standard of living problem?"

Afternoon Session: Capitol Ballroom

Moderator: John C. Leonard, M.D. director of Medical Education at the Hartford Hospital, Hartford, Connecticut, Governor of Connecticut, American College of Physicians

2:30-3:10

Medico legal problems in general practice

Russell Fisher, M.D. professor of Legal Medicine, University of Maryland School of Medicine, Baltimore, Maryland

3:10-3:50

The early diagnosis and treatment of coma

Ovid O. Meyer, M.D. professor of Medicine, University of Wisconsin School of Medicine, Madison, Wisconsin

3:50-4:05

Fifteen minute recess—coffee

4:05-4:45

Office proctology

A. F. Castro, M.D. assistant professor of Proctology, Georgetown University School of Medicine, Washington, D. C.

4:45-5:15

Questions and panel discussion

5:30-6:30

Cocktail reception—Capitol Ballroom

Wives of physicians are welcome and encouraged to attend.

No fee is required for attendance at social or scientific sessions from 9:00 A. M. to 6:30 P. M.

Five hours of formal study credit will be allowed by the American Academy of General Practice for attendance at this symposium.

THE TWENTY-EIGHTH GRADUATE FORTNIGHT

NEW YORK ACADEMY OF MEDICINE

PROBLEMS OF AGING

October 10-21, 1955

Program arranged by the Committee on Medical Education.

Six morning panels—11:00 A. M. - 12:30 P. M., Room 20 at the Academy—Monday, Wednesday and Friday of each week—October 10, 12, 14—17, 19, 21.

Nineteen hospital clinics—2:00 P. M. - 5:00 P. M. All held at local hospitals.

Ten evening sessions—8:30 P. M. Held at the Academy—Hosack Hall; 6 lecture sessions—Monday, Tuesday and Wednesday, each week; 4 panel meeting sessions—Thursday and Friday, each week.

Scientific exhibit—10:30 A. M. - 10:30 P. M. Mondays through Fridays—at the Academy. Open to physicians and students of medicine.

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program, or \$6 for either the first or second week. Fellows of The New York Academy of Medicine will receive cards of admission without application.

Medical officers of the Armed Services, in uniform, will be admitted without charge.

Interns and residents will be admitted without charge, provided they present letters from their Chiefs of Service. They will be seated as facilities permit, after Fellows of the Academy and other registrants have been accommodated.

GASTROENTEROLOGICAL CONVENTION

The Annual Convention of the American College of Gastroenterology will be held at The Shoreland in Chicago, Illinois on October 24, 25 and 26, 1955.

In addition to interesting individual papers on gastroenterology and allied fields, the program will include a panel discussion on Peptic Ulcer with Dr. Clifford J. Barborka as moderator. There will be scientific as well as commercial exhibits.

The Annual Course in Postgraduate Gastroenterology, under the personal direction of Dr. Owen H. Wangenstein of Minneapolis, Minnesota and Dr. I. Snapper of Brooklyn, New York will be given on October 27, 28 and 29, 1955 at The Shoreland. Participating in giving the Course will be a distinguished faculty from the various medical schools.

The scientific sessions on October 24, 25 and 26 are open to all physicians without charge. The Postgraduate Course will only be open to those who have matriculated in advance.

Copies of the program and further information concerning the Postgraduate Course may be obtained by writing to: American College of Gastroenterology, 33 West 60th Street, New York 23, New York.

YALE UNIVERSITY SCHOOL OF MEDICINE POSTGRADUATE SERIES IN OPHTHALMOLOGY

A series of teaching conferences planned especially for the ophthalmologist and conducted by the Section of Ophthalmology, Dr. Rocko M. Fasanella, chairman. Usually on alternate Fridays, 3:45-5:00 P. M., November 18-April 27, Beaumont Room, Sterling Hall of Medicine, Yale University School of Medicine. Fee (for series): \$15. Registration and fee to assistant dean of Postgraduate Medical Education.

November 18

Glaucoma case presentations

Drs. Louise Lovekin, Stephan Troublas, Eugene M. Blake

December 9

Strabismus case presentations

Dr. Frederick D. Williams, Andrew S. Wong, Clement C. Clarke

January 13

Ocular radiation therapy

Dr. George R. Merriam, Jr.

January 27

Case presentations

Drs. Jacob Nodelman, Frederick Mott, Francis P. Guida

February 10

Applied surgical pathology of the eye

Dr. Bernard Roberts

February 24

Case presentations

Drs. Harold C. Patterson, I. K. de Suto-Nagy, Frederick Wies

March 9

New trends in the diagnosis and treatment of diabetes

Drs. Gilbert H. Glaser, J. A. Van Heuven, Philip K. Bondy

March 30

Aqueous veins: case presentations and significance

Drs. Bernard Zuckerman, Maurice Van Lonkhuyzen, William Glass

April 13

New trends in the diagnosis and treatment of hypertension

Drs. A. V. N. Goodyer, Carl A. Jaeger, Ernest Rosenthal

April 27

Paralysis of the inferior oblique muscle

Dr. Harold W. Brown

CONNECTICUT TRUDEAU SOCIETY

The Annual Fall Meeting of the Connecticut Trudeau Society will be held at the Gaylord Farm Sanatorium, Wallingford, Connecticut, on Thursday, November 17, 1955. Once again this will be a consecutive case conference presentation.

This year the Connecticut Trudeau Society has invited the staff of the Middlesex County Sanatorium and the staff of Uncas-on-Thames Sanatorium to be participating hospital groups. Dr. Donald King has agreed to act as moderator of the session.

The following is the program schedule:

10:00 A. M. - 1:00 P. M. Morning session—medical cases.

1:00 P. M. - 2:00 P. M. Luncheon.

2:00 P. M. - 6:00 P. M. Afternoon session—surgical cases.

6:00 P. M. - 7:00 P. M. Cocktail hour, followed by dinner.

The Connecticut Trudeau Society extends a cordial invitation to interested physicians to attend this meeting.

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FOR RENT—Attractive new offices, singles or suites, with all facilities, in center of Westville, New Haven. Excellent location, corner of Fountain and Central Avenue opposite New Haven Savings Bank. Provision for parking. Also ground floor suite and suite with private entrance available. Will alter to suit occupant. S. M. Oppen Company, 16 Elm Street, New Haven, Connecticut, UN 5-3149.

NEWS

from County Associations

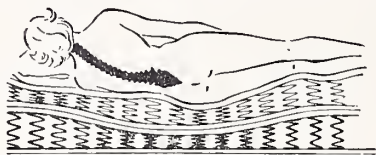
Hartford

Hartford's New Home Care Plan will be launched this fall to provide nursing, casework, homemaker and rehabilitation services for those patients who can be successfully treated for a chronic illness at home by their physicians and the community agencies operating in the Hartford area rather than in a hospital. HCMA's medical advisory board will determine medical policy. Norton Chaucer is chairman of the plan.

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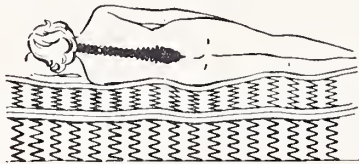
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Edward Scull of Hartford attended the Pan-American Rheumatism Congress in Rio de Janeiro, Brazil in August. He read a paper there entitled "The Combined Therapy for Rheumatoid Arthritis."

Under the auspices of the Greater Boston Education Foundation Stevens J. Martin, head of St. Francis' Anesthesiology Department, gave a lecture on "Modern Advances in Postgraduate Medical Education with Special Reference to the Field of Anesthesiology" at the Jimmy Fund Children's Hospital in Boston.

For his services to the Belgian hospital system, Wilmar M. Allen received as a tribute a bronze medal from the University of Brussels with which he worked closely through his European stay.

Over television airwaves in July (as panel speakers on a medical program sponsored by the Connecticut State Medical Society and WKNB-TV) were John F. Beakey and George Hurwitz, speaking on allergies.

Frank W. McCarthy, Jr., chairman of the Hartford Heart Association's Rheumatic Fever Committee, has announced that as of August 1 there have been 59 patients in the Hartford chapter area referred through the association for low-cost, prophylactic penicillin under the new program which began in June.

The numbers of physicians in Hartford County from 1930 to 1955 have increased 152 per cent, Philip M. Cornwell, secretary, reported in August. In reviewing the records of the association he pointed out that in 1930 there were 371 members and that 25 years later there are 917 members plus 23 applications from candidates for membership. In this span of time the association averaged new members at a rate slightly under 22 physicians per year.

Egmont J. Orbach of New Britain is the author of "Hypertensive Ischemic Leg Ulcer" published in *Angiology* issue of April, 1955.

New Haven

The general effects of the devastating flood are already well known to all. The Waterbury area was severely damaged. From the medical viewpoint many problems came up and were in general successfully met. There was the problem of transportation to patients' homes as various segments of the community were isolated. Both hospitals temporarily lost use of their utilities but these were very quickly put into action again. The outpatient de-

partments of Waterbury and St. Mary's Hospitals were heavily used by the population of the community throughout the day and night. Except for the immediate flood victims there were no traumatic injuries that are expected in the usual catastrophies.

Public health problems came up immediately as water utilities and sewage disposals were all damaged. Because of the threat of typhoid an inoculation program was started and approximately 85,000 members of the population were inoculated. Members of the Waterbury Society and Waterbury Dental Society manned the stations. The nursing profession helped tremendously at the centers.

Many medical problems arose and were solved in the best manner. In general the health of the community was maintained in an excellent condition. It would be well for all communities to review their disaster programs so that all aid can most effectively be administered at that occasion. There is no question that the Waterbury area learned a lot from their experience. It is felt that an even more effective disaster program will evolve because of the experience gained in this recent disaster.

New London

The semi-annual meeting of the New London County Medical Association will be held at the Mohican Hotel, New London on Thursday, October 6, 1955. The business meeting will precede the dinner, and a scientific session will follow. The speaker for the evening will be Dr. Arthur Tibbedeau of the New England Medical Center, his subject, "Interesting Bone Diseases." Dr. Tibbedeau is chief of orthopedics at the Pratt Diagnostic Clinic in the New England Center Hospital.

The New London County Medical Association has just purchased a new projector for the showing of slides and it will now be available at all future scientific sessions of the society.

Alfred Labensky has recently departed for Europe on an extended vacation to Great Britain and the Continent.

Middlesex

William Y. Chen, who has just completed a stint in the Army, is the new Director of Health for the city of Middletown. He succeeds John Korab who has been Acting Director for the past thirteen months.

Henry Sherwood began a residency in allergy at the University of Pittsburgh in the middle of September.

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NEW BOOKS IN REVIEW

RECENT ADVANCES IN MEDICINE AND SURGERY.

Based on Professional Experiences in Japan and Korea. 1950-1953. Medical Science Publication No. 4, Army Medical Service Graduate School, Walter Reed Army Medical Center, Washington, D. C. U. S. Government Printing Office, Washington, D. C. Vol. I, 530 pp. Vol. II, 421 pp. \$1.75.

Reviewed by HENRY M. WILLIAMS

These two volumes represent complete notes of a course conducted in April 1954 by the Army Medical Service Graduate School in Washington, D. C., and is an account of the professional experiences, problems encountered and lessons learned by the Army Medical Service during the Korean war. The authors of the seventy-nine individual papers are medical officers and consultants who served actively in the Korean conflict, and who, therefore, write with personal knowledge of their subjects. This collection of articles is of considerable interest to all physicians from four viewpoints: 1. as a fascinating medical history of the Korean war; 2. as a series of lessons that are equally applicable to medical practice in civil disasters as well as to military medicine; 3. as an account of practical experience with diseases that to many physicians still remain only textbook entities, such as smallpox, malaria or epidemic hemorrhagic fever; 4. and finally, as a source of information relevant to civilian practice, such as the management of oliguria, viral hepatitis or blood bank problems.

Volume I is particularly concerned with the surgical aspects of the Korean conflict, and begins with a general consideration of the battle casualty, including both the psychological and physiologic effects of combat and wound-

ing, as well as a detailed study of adrenal function under these circumstances. The role of the battalion aid station and surgeon is stressed in the early evaluation, management and evacuation of the wounded.

Blood replacement, complications of transfusion, the use of synthetic plasma expanders and a study of blood volume in the wounded by both the labeled red cell method (Cr^{51}) and the dye method (T-1824) are discussed completely. An excellent paper on the details of management of post-traumatic acute renal insufficiency and the use of the artificial kidney is included.

Of particular interest also is a series of papers on surgical considerations of wounds of the chest, abdomen, extremities, blood vessels, central nervous system, genito-urinary tract, eye and maxillofacial injuries.

Volume II is devoted to the medical problems encountered during the Korean campaign. An initial series of papers deals with the organization of the military medical facilities in the Far East Command, and with the training of medical personnel. Following this, some special medical problems encountered in Korea are presented including experiences in the diagnosis, prevention and management of malaria, various enteric diseases, hemorrhagic fever of the Far Eastern type and viral hepatitis. There are also papers on tuberculosis, venereal disease, plague, smallpox, Japanese B encephalitis, rickettsial diseases and leptospiroses.

Finally, considerable attention is paid to the psychiatric aspects of the Korean war, including the problems of narcotic addiction, alcoholism, combat stress and the psychiatric evaluation of repatriated prisoners of war.

After perusal of these two volumes, one is particularly impressed with the excellence of the clinical observations and research in the Korean war, the applicability of military medical experience to the problems of civilian practice, and with the magnificent service performed by the Army Medical Service during the Korean war.

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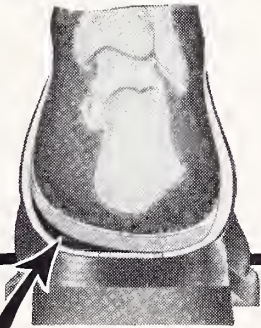
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1. Eisenberg, et al., *Antib. & Chemo.*, 3:1026-1028, Oct., 1953.



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VASCULAR DISEASE

THE management of vascular disease is based on complete diagnosis, early recognition, and control of all possible factors.

The ophthalmologist is particularly fortunate in being able to study and diagnose many forms of vascular disease. His prognosis may be of value to the patient and medical man in the prevention of vascular accidents, and occasionally in general therapy. The same principles which govern the management of all vascular disease are applicable to ocular disease of the vascular system and the importance of sound and complete diagnosis for prevention, as well as therapy, is noted in both the medical, as well as the surgical aspects of ophthalmology.

Vascular disease, like other systemic conditions, is composed of many factors, each affecting the others. Often the recognition and removal of an exciting cause will make possible relatively normal existence, even in the presence of chronic irreversible disease.

Judgment must be of the first order, if diagnosis and prognosis are to stand the test of time. There are two pitfalls the ophthalmologist must avoid if his counsel is to be respected with regard to vascular disease. The first is that he must not miss the diagnosis, or any part of it. Obviously, he must be aware of all the factors pertinent to any particular case. The history and the general appearance of the patient hold equal importance with a complete ophthalmical examination. The second pitfall he must avoid is the overemphasis of his opinion. He is usually an auxiliary, not the primary member of the medical team which is concerned with vascular problems. The ophthalmologist must not give start-

From the Ophthalmological Standpoint

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SUMMARY

Some of the responsibilities of the ophthalmologist in the diagnosis and prevention of vascular disease are described.

Aids in properly weighing the varied importance of arteriosclerosis, hypertension, diabetes, and polycythemia are also described.

Emphasis upon changes in the retinal veins as indicators of early vascular disease leads to the prevention of thromboembolic lesions.

ling information to the patient. He should funnel his information to the physician in charge, except when dealing with ocular problems.

From the ophthalmological viewpoint, vascular disease is frequently found in the retina, and in the brain, either upon neurologic, or refractive or ophthalmoscopic examination. The ophthalmologist who can differentiate between the various forms and grades of arterial diseases is well started on his role of specialization in vascular problems.

TABLE I
A SIMPLIFIED OUTLINE OF HYPERTENSION

1. GRADE OF HYPERTENSION

1. Early—angiospasm only.
2. Mild—more angiospasm with or without sclerosis.
3. Moderate—having retinitis and above (2).
4. Severe, intractable—having choked disc and retinitis and findings of No. 3.

Presented at the 28th Spring Congress, Gill Memorial Hospital, Roanoke, Virginia, April, 1955

II. OPHTHALMIC FINDINGS

- A. Grade of narrowing of arterioles. "Increased tonus."
1. 2/4 normal lumen.
 2. 1/2 normal lumen.
 3. 1/4 normal lumen.
 4. Obliterated.
- B. Grade of focal (localized) constriction. "Spasm."
1. 2/3 calibre of proximal.
 2. 1/2 calibre of proximal.
 3. 1/3 size of proximal.
 4. Invisible lumen.
- C. Grade of sclerosis of arterioles. "Organic thickening of arterioles."
1. Increased lustre.
 2. Burnished copper color.
 3. Polished silver color.
 4. Fibrous cords.
- D. Presence or absence of retinitis and neuritis.
- Early cases and those of known etiology.
- Sclerosis alone.
- Hypertension alone.
- Renal disease alone.
- Importance of retinal veins.

This is a composite table of the eyeground changes in relation to hypertension prepared by the author, based on the Keith-Wagner 1939, and Wagener-Clay-Gipner 1946, investigations and classification.¹ This material has been widely² used by ophthalmologists and internists.

Hypertension is but one of the factors to be considered in the diagnosis of vascular disease. A diagrammatic interpretation of the others may be made, as in Figure 1.

SCLEROSIS	STRESS
HYPERTENSION	DIABETES
POLYCYTHEMIC SYNDROME	OTHERS

FIGURE 1
Important factors in vascular disease

Important factors in vascular disease, frequently all of these in one case, must be recognized, and proper weight given to each factor.

The diagnosis of vascular disease is usually easy, although it becomes more difficult as it becomes more complicated. Early diagnosis is of utmost importance if the usual prognosis is to be improved. The finding of an early diabetic retinal hemorrhage, if it brings about adequate treatment, may add years to the patient's life. The prevention of a thromboembolic lesion is equally important.

In our experience the diagnosis of vascular disease is too often limited to one factor, and the other factors are left dangling without either being properly graded, or occasionally not even treated. The diagnosis of sclerosis is relatively easy for the ophthalmologist, who can see both the retinal as well as choroidal vessels. He also often notes cerebral sclerosis, because in his examinations he requires the patient to make decisions.

Stress is apparent, as well to the ophthalmologist as to other physicians. It is, in some cases, neglected, while in others, over-emphasized. The patient can perhaps best estimate the stress in his life if he is given good insight and reasonable judgment.

POLYCYTHEMIA

One of the most frequently overlooked factors adding complication to vascular disease is the polycythemic syndrome. In this group of cases we include any whose blood is more apt to clot because it is concentrated, containing more cells, more clotting elements, and less fluid, at least relatively, than normal. Sometimes this type of blood is referred to as "sludge." It is recognizable from blood studies, either the hematocrit or blood volume, and for the ophthalmologist should be recognizable in the retinal veins. The retinal veins in polycythemia are frequently engorged, often cyanotic, and sometimes show spastic changes resembling sausage-like irregularities. Prior to thrombosis in the retina these changes increase. These changes are more damaging when associated with diabetes, hypertension and sclerosis.

While the hematologists have difficulty in the classification of all types of polycythemia, the ophthalmologist also has a problem in grading the changes in the retinal veins. Sufficient importance attaches to the diagnosis of polycythemia, so that a suspicion of its presence by the ophthalmologist requires at least the reassurance of the hematocrit, unreliable though this test may be.

As can be seen from Table II, our major thesis is that the diagnosis of vascular disease should be

TABLE II
A GRADING TABLE OF VASCULAR DISEASE AS SEEN WITH THE
OPHTHALMOSCOPE

Venous engorgement polycythemic states				Normal veins				Venous spasm				Wagener's estimation of narrowing or arteriolar spasm (hypertension)			
4 3 2 1								1 2 3 4				Normal arterioles Grade of narrowing			
Thrombosis								Sausage-like Obliteration				Obliteration			

based both on the condition of the veins and the condition of the arteries. Much has been written on diseases of the retinal arterioles. Much needs to be learned about the evidences of vascular disease, as shown by the retinal veins before retinitis occurs, if possible.

We shall emphasize, especially at this time, evidence of venous disease as it is seen in the retina, beginning with thrombosis and working back to the early changes, in hopes of learning more about the prevention of thromboembolism by early and complete diagnosis. We shall review the neglected syndrome of polycythemia.

Vascular disease for the ophthalmologist shows up most frequently in three parts of the eye examination:

- 1. In examining the visual fields, where the visual pathways of the brain are involved.
- 2. In motor anomalies of the eyeball, due to affections of the cranial nerves III, IV, and VI.
- 3. In the retina.

Illustration of vascular disease in these three categories is best made by case histories. Both surgical and medical, as well as preventive methods, will be considered.

CASE HISTORY NO. 1

Mrs. C. W. reported to the ophthalmologist because of visual difficulty. A right homonymous hemianopsia was present, together with a partial right hemiplegia.

This woman of 55 had had a sympathectomy for hypertension in 1942 with benefit. She stated that she had improved enough to carry on her ordinary duties and that until the recent episode of hemiplegia she had been in relatively good health.

She went to New York for a holiday, and while seated in Radio City Music Hall suffered a cerebral vascular accident of moderately mild form. This was evidenced by the fact that she could not move her legs and she felt sick to her stomach. She was removed from the theater and after she returned home, came into our office for consultation.

It appeared that following her successful operation for hypertension she had developed the syndrome of polycythemia, as evidenced by a hematocrit of 55 and a blood volume which showed an excess of 750 cc. It was postulated that the nervous excitement of the trip to New York and the stress of the movie were sufficient to cause a vascular accident, and that the adverse effect of the excess blood volume in the presence of the hypertensive vascular damage caused the vascular accident which affected her eyes and the right side of her body.

This case is reported to illustrate that the prevention of vascular accidents may be facilitated by normalizing factors which lead to critical damage in the vascular system.

CASE HISTORY NO. 2

Mr. H. H. T., age 68, a severe diabetic, was admitted to Hartford Hospital as an emergency because of a loss of vision. The diagnosis upon admission was cerebral vascular accident, as illustrated by a complete right homonymous hemianopsia. This patient also suffered from moderate hypertension.

Within 24 hours of his admission to the hospital the visual defect had disappeared. It was postulated that he had suffered a vascular spasm involving the visual tracts of the left side of the brain and that the spasm had been overcome with a return to normal function.

The diagnosis in this case was moderately severe hypertension, severe diabetes, and the polycythemic syndrome. This patient showed a hematocrit of 50 per cent and a blood volume revealed 650 cc. excess.

He was treated by the medical service with vasodilators and the newer drugs for hypertension, together with a phlebotomy.

CASE HISTORY NO. 3

Mrs. M. M. was 68 in 1951 when she reported to our office with a venous thrombosis in her left eye. Vision in the right eye was 20/20, and in the left eye was good for counting fingers. She showed sclerosis of the retinal arteries, graded 2, together with narrowing and spasms of the retinal arteries, graded 2, and in the left eye had a thrombosis of a superior retinal vein. The macula was involved, with fresh exudate in the form of a macular star. There were numerous hemorrhages throughout the area involved. This patient was hospitalized for two weeks, where, in addition to treatment for hypertension, phlebotomies were performed to normalize her blood volume, which was elevated as follows:

HEMATOCRIT	PLASMA PROTEIN	WEIGHT
Total plasma protein	3.10 GM/K	Normal
Plasma volume	43 CC/K	Normal
RBC volume	35.2 CC/K	Excess 468 cc.
Total blood volume	78.2 CC/K	Excess 664 cc.

The patient was kept under observation and treatment for the next 6 months, during which time vision was restored to 20/20 for each eye. At this time there were still a few residual hemorrhages in the retina. The patient was being treated by phlebotomy at about every fourth month, in addition to supportive treatment. During the ensuing year the patient felt very well and the polycythemia was kept under control in her doctor's office, where his nurse performed occasional hematocrits. Through some oversight the blood volume was allowed to become elevated and one year after her first retinal venous thrombosis she suffered another one in the same eye. This was a new vascular lesion, because all evidences of the previous thrombosis had cleared up.

The same treatment was prescribed and was attended by the return of vision to 20/20, six months following the vascular accident. From this time forward, however, more careful control of the blood volume was maintained.

A third retinal venous thrombosis occurred in 1953. This time the cause was ascribed to a severe bout of bronchitis, with frequent and severe coughing. Examination of the eye at this time revealed that the entire vitreous presented a dark reflex, and it was felt that the eye was hopelessly lost. However, the patient was maintained on treatment for hypertension and polycythemic syndrome, and in six months the hemorrhages in the retina were absorbed with the return of vision to 20/30 in the left eye and 20/20 in the right eye. By December, 1954 her left retina revealed a nearly complete absorption of vitreous hemorrhages, with residual hemorrhages below the left macula and periphlebitis along the superior temporal vein. The arterial narrowing was, at this time, graded 3 and sclerosis was also graded 3.

This case is reported as the only one, to our knowledge, who has had three separate thromboses of the retina, with a return of vision to 20/20. It is to be noted that, once the diagnosis of the polycythemic syndrome is made, it may require treatment by phlebotomy or other means at regular intervals.

CASE HISTORY NO. 4

Mr. J. F. T., age 56, was referred to us with a diagnosis of venous thrombosis of the left eye, based upon hypertension and polycythemia. He visited his own eye doctor early in January, 1954 because of gradual failure of vision and in turn was referred to other eye doctors, and eventually saw Dr. Casten of Boston approximately two weeks after he lost the vision in his left eye. At this time a diagnosis of glaucoma in the left eye was also made, tension 40. The veins in both eyes appeared to be exceedingly full and cyanotic. Vision in the right eye was 20/20 and in the left eye, good for counting fingers. The patient was placed on pilocarpine in the left eye, and while he was in the hospital a diagnosis was made of diabetes, which had hitherto not been detected. The polycythemia was treated with three phlebotomies because his blood volume was elevated over 1200 cc. While in the hospital it was noted that the patient had been treated for anginal attacks in the past, based on the results of previous electrocardiographic studies.

This patient required frequent phlebotomies, in addition to the other treatment. One and one-half months after the complete diagnosis had been made, the patient had had five and one-half pints of blood removed, all of which was exceedingly thick and of a dark blue color.

This case is reported to emphasize the importance of the polycythemic syndrome, not only in regard to retinal venous thrombosis, but also in regard to cardiac vascular disease. The electrocardiographs taken after the phlebotomies revealed a lessening ischemic pattern when compared to the previous tracings taken before the diagnosis of polycythemia was made. It is notable that when venous thrombosis begins to develop it is possible to prevent development of thrombosis of all branches of the retinal veins when early treatment is possible, especially in cases of polycythemia and diabetes associated with hypertension. This patient has required phlebotomies, more than one a month, during the first seven months of his treatment.

CASE HISTORY NO. 5

Mr. W. F. D., age 57, another executive, was under treatment by a medical man because of a mild heart attack in June, 1953 and was referred to us because he noted blurred vision and slight difficulty in driving his car. A diagnosis of polycythemia had been made, and the patient was under treatment with isotopic P₃₂. Our examination revealed scars in the retina from previous hemorrhages and evidence of hypertension, Grade 2. There was some evidence of atheromatous plaques in some of the retinal arteries. The retinal veins were graded as engorgement No. 2.

The patient's blurred vision was found to be due to 2.00 diopters of right hyperphoria and prisms were placed in his glasses. The new finding of hyperphoria was attributed to a cerebral vascular accident, affecting the oculomotor nuclei.

A diagnosis of insufficiently treated polycythemic syndrome was made, and treatment by phlebotomy was carried

out. In the ensuing four months several phlebotomies were performed, so that the patient had given, since his heart attack the year before, 30 pints of blood.

The results of treatment were satisfactory and in the ensuing year the prisms were removed from his glasses, and he was allowed to work for half days. He was kept under close observation for elevations of blood volume, and for the past two years has been free of further vascular accidents. Vision is 20/20 for each eye.

CASE HISTORY NO. 6

Mrs. T. K., age 63, was admitted to the hospital for cataract extraction. Her case is being reported in this group to illustrate the importance of stress in the production of diabetes and allergic manifestations, and furthermore, to show that even under general anesthesia the subconscious effects of stress cannot be controlled. When stress is an additional factor with diabetes, hypertension, and with or without the polycythemic syndrome, it requires additional therapy.

Upon admission to the hospital this patient was found to have exceeding evidence of stress, together with hypertension, and all efforts were made to control the important factors. In spite of the use of general anesthesia and heavy sedation, the patient experienced, in the first 24 hours following the operation, considerable gastric and bowel spasms. Beginning one day following the operation, both eyelids were acutely swollen and reddened without any evidence of pathology other than severe stress. Her diabetes, which was discovered on her admission to the hospital, was treated with insulin for two days. As the stress from the operation subsided, the patient's condition became normal, even the diabetes subsided.

This case illustrates a syndrome we call stress diabetes and which we have found in 10 out of 100 operations for cataract or glaucoma.

CASE HISTORY NO. 7

Mrs. H. W., a 55 year old, stout woman with long standing diabetes, was to be admitted for cataract surgery. She was prepared in the office of her physician and entered the hospital in good diabetic control.

We thought she was in good shape for surgery, since her hematocrit was only 45, or one point above our arbitrary normal for females. However, the blood volume showed:

Conclusions: X8.4 units whole blood based on expected weight of 142.

Hematocrit 45	Plasma protein 8.2	Weight 65 K
Total plasma protein 4.49 GM/K	Excess 103.5 GM	
Plasma volume 54.5 CC/K	Excess 950 CC	
RBC volume 44.6 CC/K	Excess 1080 CC	
Total blood volume 99.5 CC/K	Excess 2030 CC	

She had previously had a phlebitis of the left leg, and we were concerned over another thrombosis.

As you can see from the report, she showed an excess of 2030 cc. total blood volume. We performed phlebotomy and reduced her blood volume to normal. She went through the operation uneventfully and was discharged with a fine eye.

When can the ophthalmologist make a diagnosis of importance in vascular disease?

Ordinarily it will be in a person past middle age, and the easy diagnoses are made following major vascular accidents. We should aim to make the diagnosis earlier and prevent vascular accidents.

Very little help can be offered the patient who has suffered a major vascular accident, but there are times when exceptions to this rule occur. Cases 3 and 5 are illustrations of recovery from vascular crises which are ordinarily followed by pronounced morbidity, and often within a few years by fatality.

One of the most important roles for the ophthalmologist is in the early recognition of vascular disease before severe vascular crises have occurred. Just as hypertension can be controlled with more ease in the milder grades, so can other factors which adversely affect the vascular tree. The polycythemic syndrome should be recognized when the veins of the retina are engorged to grade III without difficulty.

If there is some question as to the grade of venous engorgement, the ophthalmologist may request a hematocrit.

Table III reveals the incidence of polycythemia, based on preoperative hematocrit studies in 450 patients.³

TABLE III
CLINICAL CLASSIFICATION

- 450 patients with hematocrits of 50 or above.
- 346 patients or 75.4 per cent had absolute polycythemia.
- A. Polycythemia vera B. Secondary polycythemia C. Artificial polycythemia.
- 113 patients or 24.6 per cent had hemoconcentration (relative polycythemia).

TABLE IV
INCIDENCE OF ABSOLUTE POLYCYTHEMIA

- With hematocrit 50-54 (320 patients)—223 or 70 per cent had absolute polycythemia.
- With hematocrit 55-60 (100 patients)—85 or 85 per cent had absolute polycythemia.
- With hematocrit 60 plus (39 patients)—38 or 97.4 per cent had absolute polycythemia.

ABSOLUTE POLYCYTHEMIA WITH 1,000 CC. OR MORE EXCESS OF RED CELL VOLUME

- With hematocrit 50-54 (320 patients)—50 patients or 15.6 per cent.
- With hematocrit 55-59 (100 patients)—34 patients or 34.0 per cent.
- With hematocrit 60 plus (39 patients)—37 patients or 95.0 per cent.

Polycythemia is a complicated syndrome, and while polycythemia vera is diagnosed easily but rarely, the other types of polycythemia occur more frequently and are often not diagnosed⁶

TABLE V
DIFFERENTIAL DIAGNOSIS OF POLYCYTHEMIA

	PRIMARY POLYCYTHEMIA	SECONDARY POLYCYTHEMIA	STRESS (SPURIOUS) POLYCYTHEMIA
Red blood cells	+++	++	+
Hemoglobin	+++	++	+
Hematocrit	+++	++	+
White blood cells	N to ++	+	+
Platelets	+++	N	N
Differential blood count	left shift in polymorpho- nuclears	N	N
Arterial oxygen saturation	N	—	N
Red cell volume	+++	++	N
Plasma volume	++	+	—
Total blood volume	++++	++	—

+ increase; — decrease; N normal
*Polycythemia. Postgrad. Med. 16:405-412, 1954

Figure 2 reveals the various types of abnormality which may occur in blood volume.³

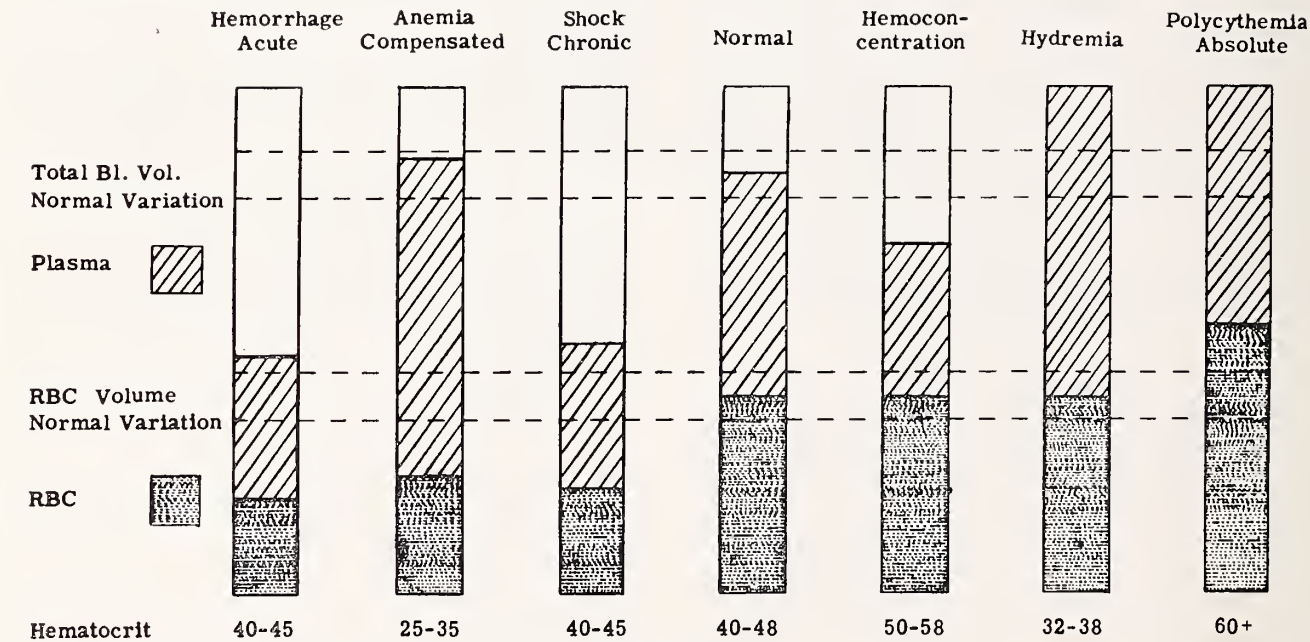


FIGURE 2

Table VI enumerates the various clinical causes of the polycythemic syndrome, and suggests the wide scope of the diagnosis.

TABLE VI
THE SYNDROME OF POLYCYTHEMIA

1. Polycythemia vera.
2. Relative polycythemia due to:
 - a. Altitude changes
 - b. Dehydration
 - c. Over transfusion

- d. Cardiac disease
 - 1) Congenital hearts
 - 2) Decompensated hearts
- e. Lung disease
 - 1) Malignancies
 - 2) Emphysema
- f. Overeating and drinking

The ophthalmologist is certainly entitled to use the general appearance of the patient, as well as the history in supporting his diagnoses. The polycythemic patient may show either a florid complexion

or be pale. He may be overweight or relatively normal in weight. He may have dizziness, fullness of the head, and pains in the legs when walking. He may suffer from fatigue and epistaxis.

That polycythemia causes thromboembolic lesions is noted in widespread reports in the literature. One of the strong facts in support of the danger of vascular lesions in polycythemics is the record of the autopsies performed at the Mayo Clinic by Stroebel, Hall and Pease, noted in Table VII.

Polycythemia⁴ has frequently been associated with retinal venous thrombosis.⁵

TABLE VII
CAUSE OF DEATH IN THIRTY-TWO PATIENTS WITH
PRIMARY POLYCYTHEMIA

THROMBOSIS	NUMBER	PER CENT
Coronary	8	25
Mesenteric	3	9.4
Hepatic	1	3.1
Hemorrhage		
Cerebral	3	9.4
Gastrointestinal	3	9.4
Chronic myelogenous leukemia.....	4	12.5
Malignant tumors	4	12.5
Peritonitis	2	6.2
Others	4	12.5

(Stroebel, C. F., Hall, B. E., and Pease, G. L.)

This table deals only with true polycythemia. All forms of polycythemia—the syndrome—have similar incidences of thromboses and hemorrhage.

The importance of the syndrome to the surgeon is evident. It must be recognized.

Complications resulting from undiagnosed and untreated polycythemia of any form may be expected to include:

- 1. Hemorrhage.
- 2. Thrombosis.
- 3. Anesthetic problems.
- 4. Surgical problems.
- 5. Difficulty in convalescence.

We have not emphasized the importance of polycythemia in surgery but have found that we must

recognize and treat it to avoid surgical complications. We routinely note the hematocrit and order blood volume tests on all patients of suspiciously high levels, especially in cases where the retinal veins are not visible.

TABLE VIII
TREATMENT OF POLYCYTHEMIA

- I. Most satisfactory
 - A. Phlebotomy
 - B. P₃₂
- II. Less advantageous
 - A. Phenylhydrazine
 - B. Fowler's solution
 - C. Nitrogen mustard
 - D. X-ray therapy

While the treatment of polycythemia is the responsibility of the medical man and is outlined in Table VIII, the importance of the ophthalmoscope in making an early and complete diagnosis of vascular disease is to be kept in mind.

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CERVICAL PATHOLOGY AND STERILITY PROBLEMS

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ABNORMALITIES of the cervix and endocervix have long been considered as one of the major causes of infertility. As far back as 1855, Augustus Gardner in a book entitled "The Causes and Curative Treatment of Sterility" stated: "By far the commonest cause of sterility is from disease of the os externum,"¹ and J. Marion Sims, this country's most outstanding gynecologist, wrote in 1866: "If I were asked what next to mere mechanical obstruction of the cervix uteri constitutes the greatest obstacle to conception, I would have no hesitation in saying that it was an abnormal secretion from the cervix."²

In further discussing the subject, Gardner stated that so little was known of the cervix in "its minute anatomy and its physical action and sympathies either in the healthy or diseased state,"³ that he could really come to no conclusions concerning its physiology. Although this was said 100 years ago, and although great progress has, of course, been made in the knowledge of the anatomy and physiology of the cervix since then, it may still be said that our ignorance concerning the pathological potentialities of this organ in connection with sterility is considerable.

In the nonpregnant state, the cervix is a pathway through which sperm may find their way into the uterus and tubes, and is a means of egress for the menstrual flow. Apparently, as a process of teleological activity in connection with sperm migration, it goes through definite physiological changes throughout the menstrual cycle, and part of this discussion concerns these physiological changes and their pathological aberrations.

ANATOMY OF THE CERVIX

First, however, I would like to mention a few points which might be considered important concerning the relationship of the anatomy of the cervix to infertility. Differences in the shape and size of the cervix were emphatically stressed as sterility factors by such writers as Sims and Gardner

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SUMMARY

Attention is called to the paucity of information concerning the role of the cervix in sterility. The real value of anatomical peculiarities of the cervix in their relation to infertility is pointed out. The old theory of malpositions of the uterus as a cause of sterility is exploded.

The role of the cervical mucus in infertility and its significance in the postcoital test is discussed. The author describes his method of performing this test and the results to be expected when the test is considered normal.

Finally, the role of bacteria present in the cervix is considered and it is pointed out that organisms found in the cervical canal, although spermicidal in vitro are not necessarily spermicidal in vivo. In the presence of chronic cervical catarrh, however, infection must be cleared up to produce normal mucus and remove a barrier to conception.

and European gynecologists interested in this problem at that time. Sims believed that the small and conical cervix was conducive to infertility and, as a matter of fact, he was probably right in this conjecture; not because the cervix when shaped this way is necessarily a mechanical or physiological factor in preventing conception, but because it is representative of estrogenic inadequacy. The amenorrheic or anovulatory woman who has a greatly lowered amount of estrogenic ovarian activity is not only infertile, but also frequently has the small conical shaped cervix which Sims describes.

Investigators and writers in the early twentieth century were greatly impressed by the possibility that a tight external and internal os and small cervi-

cal canal might be an infertility factor, and it was a popular procedure to carry out frequent and extensive cervical dilatation for the purpose of increasing the size and diameter of the cervical canal and thus, apparently, alleviate infertility. We now know that it is very doubtful if the tightness of the internal or external os or the narrow diameter of the cervical canal has anything to do with infertility, except in rare instances. Rarely, the canal may be somewhat dilated and the external os so small that it prevents the proper drainage of inspissated and thick mucus from the canal itself. In this situation the normal flow of cervical mucus is prevented by the smallness of the external os; the cervical mucus is retained within the canal to the point where it becomes thick, viscus and infected, and this acts as a mechanical and possibly bacterial barrier to sperm migration. It must be remembered, however, that this is definitely not true when the entire cervical canal itself has a small diameter and mucus is not being secreted to any great extent by the cervical glands. This latter condition is probably due to insufficient estrogenic stimulation to the cervix and must be treated accordingly. Thus it may be said that anatomical peculiarities of the cervix are more valuable in identifying underlying hormonal abnormalities in the patient which may be a cause of infertility than they are in being etiological factors themselves.

It has been thought in the past and is still thought by some individuals at the present time that abnormalities in the position of the cervix may well be an infertility factor. In cases of acute retroversion where there is not a very pronounced retroflexion, the anatomic relationships within the vagina may be so altered that the cervix points upward and the external os rests beneath the symphysis pubis. In this situation the postcoital seminal pool lies in the posterior fornix which may be a considerable distance from the external os of the cervix and thus be considered a mechanical factor in the production of infertility. It may easily be determined if this is a factor by carrying out a postcoital test at the appropriate time in the cycle to see whether or not sperm actually find their way into the somewhat distant cervix. It has been the author's experience that a good postcoital test is found in situations like this about as often as it is when the cervix is in normal position and, therefore, it is very doubtful whether this type of malposition is of great significance in infertility.

We must conclude then that anatomical abnormalities of the uterus and malpositions of the cervix are rarely important factors in the problem of infertility unless they are extreme. The cervix as an infertility factor is such because of pathological changes in the physiology, the chemistry, and possibly the bacteriology of the cervical canal.

PHYSIOLOGY OF THE CERVIX

Within recent years one of the most interesting physiological changes that occurs in the menstrual cycle has been investigated and studied by a number of workers both here and abroad. This is the cyclic change that the cervical mucus undergoes during different times in the menstrual cycle. Apparently, as a result of stimulation by estrogen and progesterone, the cervical glands secrete cervical mucus in different amounts and with different physical and chemical characteristics at different times in the cycle. Nature has so arranged these changes that somewhere around the ovulation date the characteristics of the cervical mucus are radically altered in such a way that it becomes an ideal medium for the transportation, and possibly even the nutrition of sperm. During the first part of the cycle, after the cessation of the menstrual flow, the cervical mucus is scanty, thick, viscus, with a low acid pH and a high cellular content.

This mucus undergoes a very interesting change a day or two before the occurrence of ovulation or in a normal 28 day cycle at about the 12th day. The heavy white cell infiltration of the previous days miraculously disappears, the mucus becomes much more hygroscopic, and thus its flow elasticity becomes much greater and its viscosity much thinner. The pH of the cervical mucus at this time undergoes a very definite change to an alkaline level and the chemistry of the mucus also changes so as to acquire a considerable content of mucoprotein and polysaccharide probably consisting mostly of glycogen. All these changes result in a medium which is admirably suited to sperm migration at a time in the cycle when it is obviously most important for the purposes of reproduction to have a suitable environment through which sperm can travel in their process of finding the ovum. Figures 1 and 2 taken from Pommerenke⁴ are a graphic representation of these changes which the cervical mucus undergoes at the ovulation date. There is a correlation between the basal body temperature as an indicator of ovulation, the amount of the cervical mucus at the ovulation date and the great decrease in viscosity at this

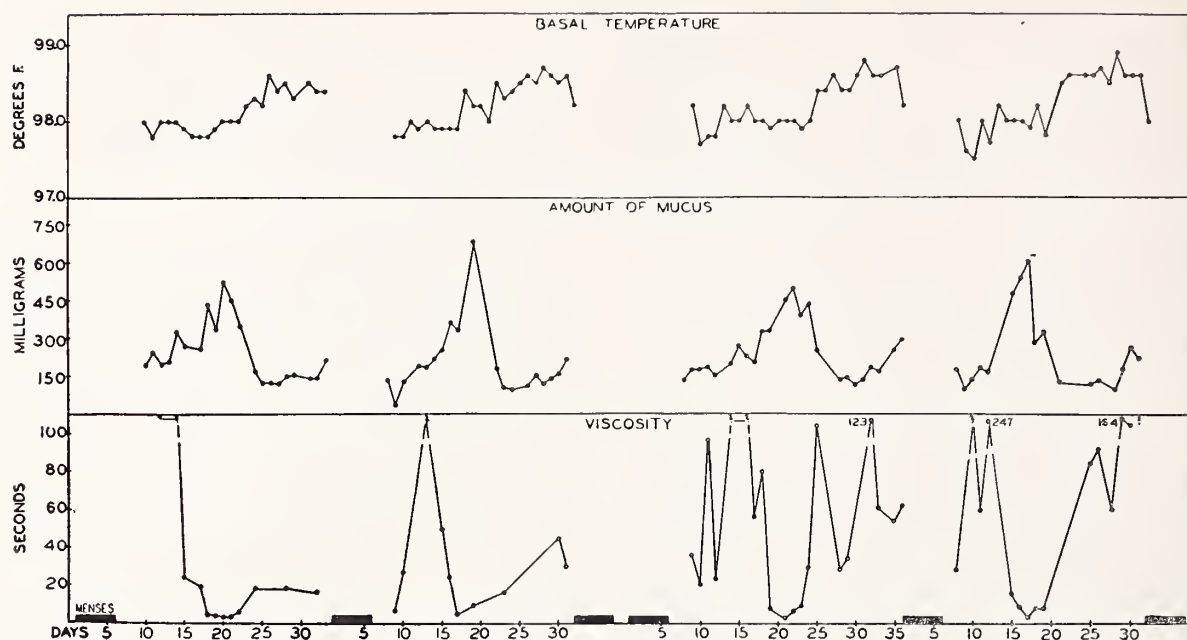


FIGURE 1

Relation between basal temperature, amount and viscosity of cervical mucus for Subject 6, a 25 year old nullipara. Cycles 6 and 7 were consecutive, as were Cycles 8 and 9. In the viscosity curve, ? indicates that the viscosity was beyond the range of the method, and o indicates that a pressure greater than 4.1 cm. was necessary to move the column, the appropriate corrections having been applied.

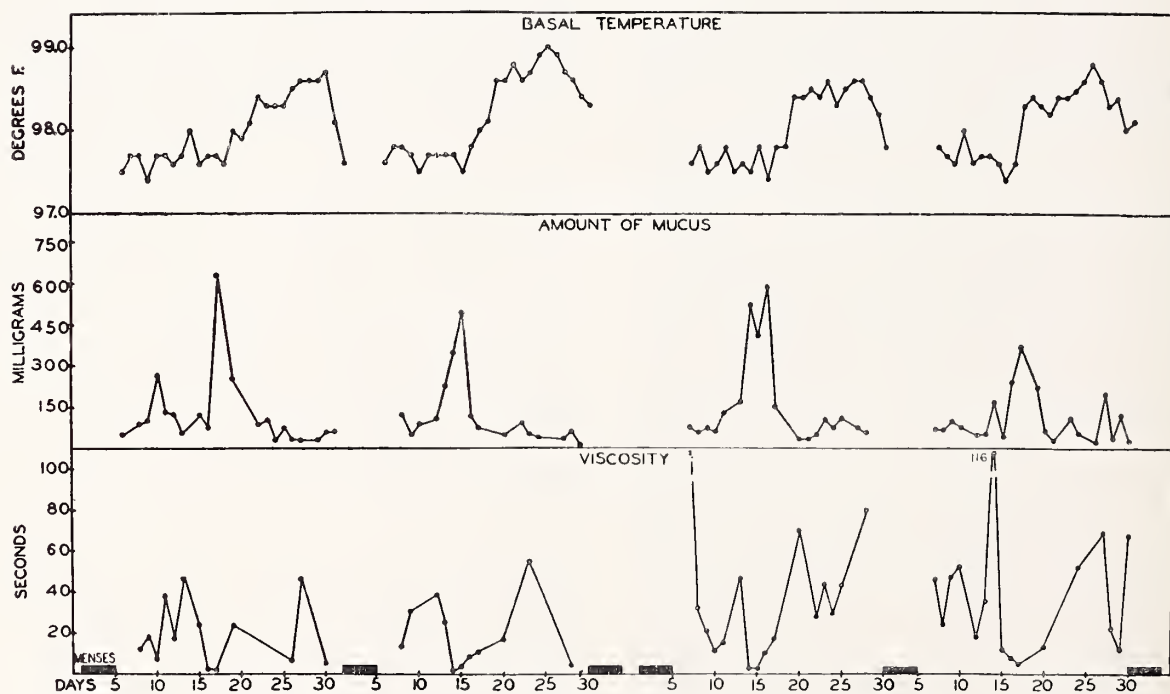


FIGURE 2

Relation between basal temperature, amount and viscosity of cervical mucus for Subject 7, a 24 year old nullipara. Cycles 2 and 3 were consecutive, as were Cycles 4 and 5. Symbols as explained under Figure 1.

time. Figure 3 also from Pommerenke shows a rather interesting correlation between the great decrease in viscosity and the increase in the permeability of cervical mucus by sperm. These physical characteristics and the changes in the chemical constituents of the cervix at the ovulation date are, as has been mentioned, naturally of great importance in the process of reproduction. It is, therefore, apparent that it is most important for the physician investigating sterility problems to carry out his investigation of the cervical mucus within the few days of the cycle around the ovulation date and only at this time. Examination of the cervical mucus at any other time than the ovulation date thus might well produce a false impression of mucosal abnormality or infection, and is therefore valueless. This is especially true when carrying out postcoital tests because in a normal individual, if a postcoital test is carried out at any other time than the ovulation date, the characteristics of the cervical mucus are very probably such that the test will be an extremely poor one.

This brings us to a more extensive discussion of a test which has been carried out in problems of in-

fertility for over 100 years, and which is of great importance, but which, surprisingly enough, seems to be neglected by a great many investigators of infertility problems. As recently as three months ago an extensive analysis of the investigation and treatment of a large number of sterile couples was published in one of our specialty journals without even a mention of this important test.

This test has been carried out in several different ways and its first use attributed to several different specialists. It is frequently called the Hühner test in this country after Dr. Hühner of the Mt. Sinai Hospital in New York who popularized it over 30 years ago. Actually this test is extensively described in almost exactly the fashion in which it is used today by J. Marion Sims in his "Treatise on Uterine Surgery" which was published in 1866. Therefore many clinics in this country and a large number of clinics abroad call this the "Sims Test." However, it was brought to my attention by one of my confrères in the Sterility Clinic of the Sloane Hospital for Women that a man named Smith in North Carolina published an account of this test in 1847, and although I have not been able to find this refer-

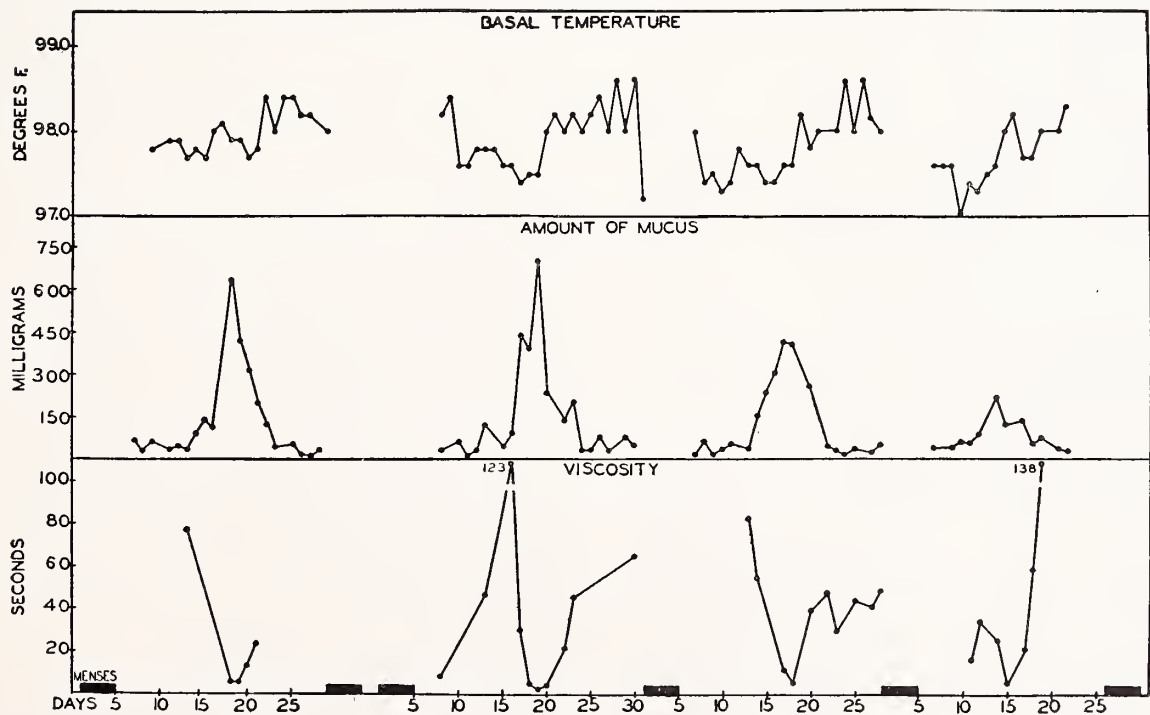


FIGURE 3

Relation between basal temperature, amount and viscosity of cervical mucus for Subject 8, a 24 year old nullipara. Cycles 2, 3, and 4 were consecutive. Cycle 4 was not completed because of illness after the twenty-first day. Symbols as explained under Figure 1.

ence, I strongly suspect that it was described as early as this time and very probably a lot earlier. When we realize that sperm were first seen under the microscope in the year 1677, it would not be very surprising if sometime between then and now some curious individual had investigated the progress of sperm through the female genital tract. Therefore, in the interests of history and fairness to some unknown originator, it seems simplest to call this examination simply the "postcoital test."

As has been mentioned above, it is most important to carry out this test somewhere around the ovulation date which is most easily determined by the examination of basal body temperature charts. The test done at any other time is useless. It is naturally difficult to predict the time of ovulation with any accuracy in women who menstruate somewhat irregularly. Therefore sometimes it is necessary to make a guess as to when the ovulation date will probably arrive and arrange for a postcoital test at this time. If subsequent observation of the basal body temperature charts discloses the fact that ovulation has not occurred, then the test may be repeated at frequent intervals until one test is found to coincide with the basal body temperature rise indicating the proximity of ovulation.

The technique of carrying out this test, and the time following intercourse at which it is done, has varied considerably in different clinics and through different years. Sims originally advised a time of ten to twelve hours postcoitally, and this is probably as good advice as any. In his experimentation on this subject he did tests at times varying from one to two minutes postcoitally up to several days. These investigations have been repeated by numerous people through the years and at one time it was thought advisable that this test be carried out as soon after intercourse as possible. This is not considered necessary any more, however, and if carried out any time between about six and about twenty-four hours postcoitally it is thought to be satisfactory, although as the years go on further knowledge of the chemistry, physiology and bacteriology of the cervix may somewhat change this concept. The test is frequently carried out by the removal of cervical mucus from the cervical canal with a suction pipette, but it has been our experience that the use of a Knight nasal polyp forceps is the most convenient and satisfactory technique. The advantages of this instrument are that it is more convenient to use and easier to clean, plus the fact that

specimens can be taken from different levels of the cervix and thus some idea obtained concerning the relative progress of the sperm through the cervical canal. Our procedure is usually to take a specimen from the level of the external os and place it on a glass slide for future inspection, and then with the forceps closed, to insert the tip to the level of the internal os, slightly open the forceps so that the forceps blades will fill with mucus, and after placing this on a glass slide, compare the two levels for quantity and motility of the spermatozoa.

There are several things to observe at the time of the postcoital test. The first is the quantity and the characteristics of the cervical mucus. If at the ovulation date the cervical mucus is thick and viscid and cellular, it indicates the probability that either the patient is not ovulating or that there is some infection of the cervical canal and its racemose cervical glands which produce this variety of thick, viscid, cellular mucus. This type of mucus varies all the way from a material which is jelly-like in consistence, very tenacious and yellowish to yellowish brown in color, to a somewhat watery material which, nevertheless, is grayish white because of its cellular content. It is easy to see that in the former case it is physically impossible for sperm to find their way through this thick gelatinous, infected mass and in the latter case the characteristics are such that sperm either do not progress through the material, or frequently die shortly after their arrival therein.

It has often been asked, "How many live active sperm must be seen in a high power field to constitute a normal postcoital test?" and, of course, this question is impossible to answer. It has been stated that one live active sperm should constitute a normal test because of the assumption that only one normal sperm is necessary to fertilize an egg and produce a pregnancy. This assumption, however, may not be correct. Recent studies have indicated that it may take a number of sperm affecting a concentrated action on the periphery of an ovum to permit one sperm to penetrate the zona pellucida and thus fertilize the egg. Since we have no really accurate way of determining what a normal postcoital test is, it seems reasonable to assume that if the cervical mucus is thin and clear and hygroscopic, and has in it many live active sperm per high power field, this constitutes a normal test. Abnormal tests might be said to be those conditions in which there are either no sperm present no matter what the type

of cervical mucus is, or a number of dead sperm present, or only rare viable sperm in the presence of abnormal appearing cervical mucus.

If no sperm are found on repeated postcoital tests, even in the presence of normal appearing cervical mucus and at a time which is reasonably assumed to be the ovulation date because of the change in basal body temperature chart, a search must be made to find the cause of this abnormal situation. The male may have azospermia or a very low count. The technique of coitus may be unsatisfactory or some anatomical abnormality in the female may prevent the proper deposit of semen in the posterior fornix of the vagina. If the husband's sperm count is normal, and if by thorough questioning it is found that the couple are having no difficulty with the technique of coitus, it must be assumed that some anatomical abnormality is present. An extremely short vagina or a retroverted uterus of the type which was described previously may be the cause of the abnormal postcoital test. In a situation such as this where the cervical mucus appears to be normal, artificial insemination with the husband's specimen on several occasions at about the ovulation date may well solve the difficulty. If this is done, it is advisable to examine the cervical mucus 24 hours after insemination to find if the artificial insemination was properly carried out.

If, on the other hand, the cervical mucus is found to be of the chronically infected catarrhal type at the time of ovulation, some steps must be taken to correct the chronic cervical infection and enable the cervical glands to produce normal mucus which is more amicable to sperm migration. Numerous techniques have been advised in the past for the correction of the chronic endocervicitis which produces cervical catarrh and infected mucus. One of the most popular techniques of a number of years ago was conization of the cervical canal with either the actual or the electrocautery. This technique is mentioned only to be condemned because cauterization destroys most of the racemose cervical glands, which is, to be sure, a good technique for curing the infection, but which also prevents the endocervix from producing normal cervical mucus in the future, and a dry mucusless cervical canal may be as much of a deterrent to sperm migration as one that is filled with infected mucus.

Instead of cauterization of the cervical canal, the judicious use of local and systemic antibiotics fre-

quently cleans up the infection and allows the cervical glands to function normally. In addition to this it is sometimes important to correct a condition which was mentioned in one of the earlier paragraphs of this paper, and that is the anatomical abnormality in which there is a very tight external os and a rather full and dilated cervical canal which acts as a repository for the cervical mucus. This trapped material within the cervical canal becomes dehydrated and infected and becomes that jelly-like material so resistant to sperm penetration. In situations like this a dilatation of the external os or even a small, bilateral incision of the external os is advisable for appropriate drainage of the cervical canal.

BACTERIOLOGY OF THE CERVIX

The observation that certain bacteria cultured from the cervix had a deleterious effect on sperm in vitro was made in 1950. This observation led to an investigation of the possible etiological role of these organisms in sterility. Various types of organisms were found to be spermicidal in vitro, the most common of which was *E. coli* and various associated organisms of a similar type. They produce a spermicidal effect by clumping the sperm and shortly thereafter the sperms lose their motility and apparently die. Figure 4 shows a titration of *E. coli* in a constant concentration of sperm.⁵ Maximum agglutination of sperm occurs in the tube containing 300,000,000 *E. coli* per cc. and there is a decreasing agglutination of sperm in subsequent test tubes as the concentration of the *E. coli* is diminished.

Various streptococci and other less frequently found organisms were thought to be spermicidal but in a somewhat different way.

It was thought, therefore, that possibly the reason for poor postcoital tests in individuals with infected cervixes was because of the presence of spermicidal bacteria, and a decision was made to culture the cervix in cases of infertility to find out more about the cervical bacterial population.

This inaugurated an investigation of cervical bacteriology in problems of sterility which extended over a five year period and which has been fully reported upon elsewhere.⁵ It was clear that the coliform group of organisms, especially *E. coli*, were highly spermicidal in vitro. It was also clear that although various streptococci and other less frequently found organisms had spermicidal characteristics, it was questionable whether the action was rapid enough to be of clinical significance.

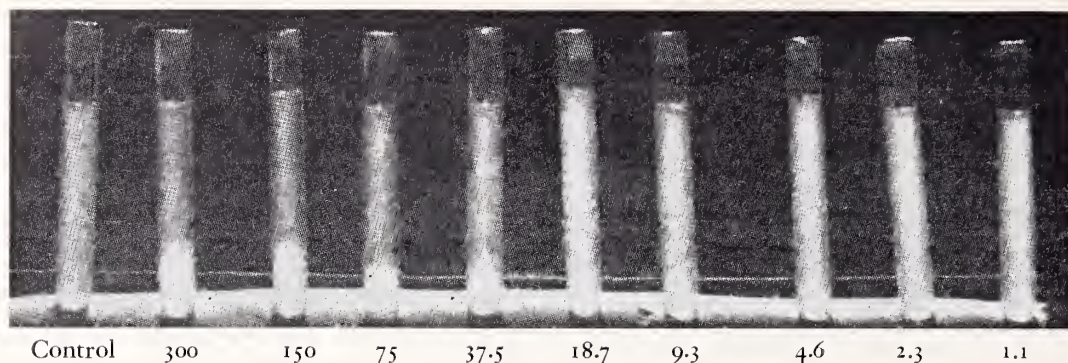


FIGURE 4

Macroscopic tube agglutination test after one hour. The tubes contained a constant concentration of 50 million spermatozoa per ml. and varying concentrations of *Esch. coli*. The control tube remained uniformly turbid throughout the length of the test. The numbers under each tube indicates *Esch. coli* concentration in millions/cc.

At the present time we must conclude that although the presence of spermicidal bacteria in the cervical canal may possibly have some effect on sperm migration, it has as yet by no means been proved, and unless these pathogenic spermicidal organisms also produce changes in the mucosa and glands of the cervical canal, they cannot at the present time be considered of great significance.

In conclusion then, we may make the following statements in connection with the influence of the cervix on problems of infertility.

1. Anatomical abnormalities in the cervix are more likely to be an indication of some sterility producing hormonal aberration in the individual than they are actually sterility producers themselves.

2. Malpositions of the cervix and uterus may be considered as a causative factor of sterility only in very rare and unusual circumstances.

3. The most significant cervical sterility factor is a change in its cyclic mucus producing potentialities. The cervical glands must produce a type of cervical mucus at ovulation time amenable to sperm migration.

4. Although bacteria found in the cervix are found to be spermicidal when mixed with sperm in vitro, it has not as yet been proven that these organisms when found in the cervical canal actually kill sperm in vivo and thus produce a bacterial barrier to spermatogenic progress. If, however, these organisms or any other organisms produce a chronic cervical catarrh, this so alters the production and type of cervical mucus that sterility occurs and the infection of the cervix must be corrected so that the production of cervical mucus may become normal again.

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IMPORTANCE OF BLOOD SEDIMENTATION RATE

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FOR many years it has been my custom to include the Blood Sedimentation Rate (BSR) as a routine procedure during each complete physical examination. An elevated B.S.R. in the presence of negative physical findings was my criterion for advising the patient that further clinical investigation should be carried out to arrive at a diagnosis.

CASE REPORT

Mrs. Y. G., 51, mother of two healthy children and giving no history of any previous illness, reported to my office in January, 1954 for a "check-up." During the history taking the patient admitted having some migrating pains between the right knee, hip and ankle, but she paid little attention to these symptoms and it was considered by the examiner to be of no greater degree than what any patient might record when being questioned. She was moderately obese, weighing 165 pounds, blood pressure was 132/86, and the heart appeared normal with an apical and pulse rate of 76. Abdominal and vaginal examinations were not satisfactory because of the obesity. Inspection of the vagina with a speculum revealed a minute cervical polyp with an accompanying slight cervicitis. A smear was taken for Papanicolaou stain and later reported as Class I (atrophic; blood cells 1 plus; pigment 1 plus; leucocytes 2 plus). Rectal examination was negative. A routine complete blood count and B.S.R. were done. While the former was within normal limits (R.B.C. 3,890,000; W.B.C. 7,600 with normal differential; hemoglobin 12.15 gm. or 78.3 per cent) it was a great surprise to find the B.S.R. to be 88 after one hour. Repeated B.S.R. the following day gave the same result. Because of this finding the patient was advised to have a complete work-up and was therefore booked for admission to St. Francis Hospital on January 31.

In the hospital a gastrointestinal x-ray series was reported negative, but the radiologist noticed a large cystic mass replacing the right iliac crest, suggesting the presence of a tumor involving the right ilium (Figure 1). Further x-ray studies including the entire skeleton, an intravenous pyelogram, and special films of the pelvis revealed no other pathological lesions. It was concluded, therefore, that the tumor was primary in the ilium. An aspiration biopsy specimen was obtained on February 7 and reported to show fibrosarcoma, grade 1. Blood studies done in the hospital were within normal limits, except for the alkaline phosphatase test which was slightly elevated to 9 K.A. units. Hemoglobin had dropped to 75 per cent, N.P.N. was 34 mgm. per cent; blood sugar, 87 mgm. per cent; blood calcium, 10.1 mgm. per cent; phosphorus, 4.4 mgm. per cent;

cephalin flocculation, negative; total protein, 6.5 with albumen 4.8 and globulin 2.4.

Because of the seriousness of the diagnosis and the question of an hemipelvectomy which arose, the patient was referred to the Memorial Hospital in New York City. An aspiration biopsy specimen obtained there was unsatisfactory, hence an open biopsy was performed on February 15. Diagnosis by the pathologist was chondromyxoid fibroma. Ten days later a wedge resection of the wing of the right ilium was done. The patient stood the procedure well. The operative specimen showed a clear margin about the excised tumor. The final report read as follows: "Diagnosis was varied within our group. Consulted with Dr. Henry Jaffe who concluded that this was a chondromyxoid fibroma."

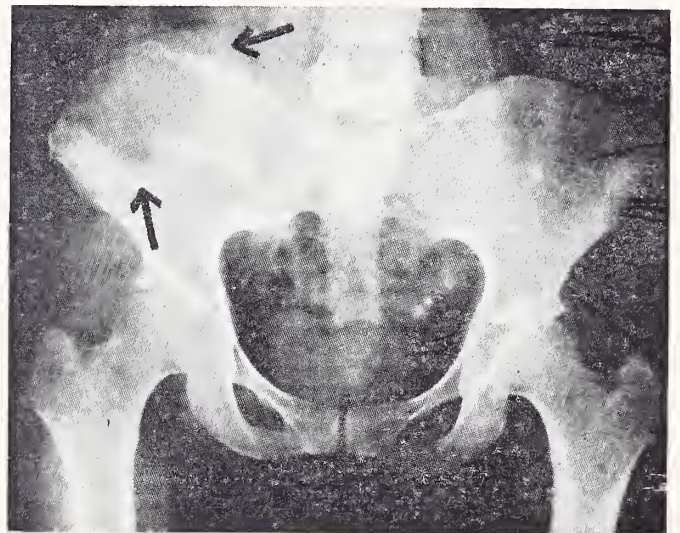


FIGURE 1

Since her discharge from the hospital on March 12, follow-up examination on April 2 showed a B.S.R. of 98 but this might well have been due to drainage from the operative wound with sloughing of a few deep sutures. On June 8 the B.S.R. was 48 and on August 6, 35. On this last date the patient was feeling well, the wound was completely healed, and an x-ray of the right ilium showed a well defined operative margin with no evidence of recurrence (Figure 2). In October the B.S.R. rose again to 55 and at the same time there was redness and swelling of the operative scar of about eight days' duration. A local recurrence of the tumor was considered, but x-ray of the pelvis showed no change. A biopsy revealed only inflammatory tissue. Following this procedure several more sutures were expelled from a fistula

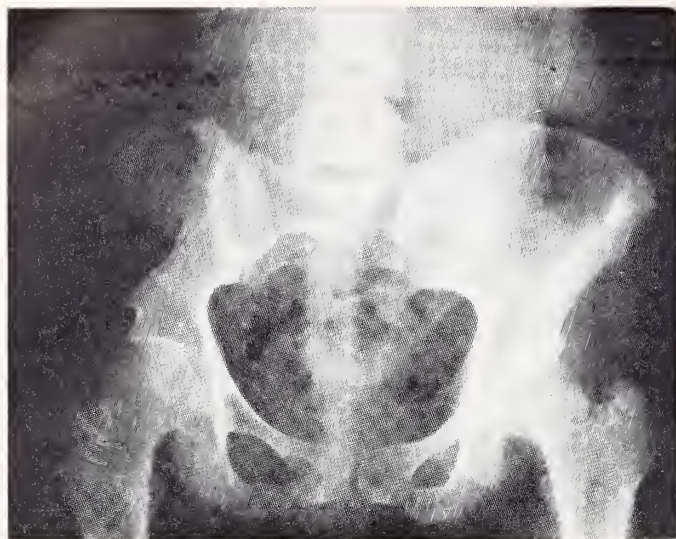


FIGURE 2

at the site of the operation. After several weeks the fistula closed spontaneously. The B.S.R. followed exactly the progress of healing. On January 4, 1955 for the first time since the initial visit the B.S.R. was down to 18.

This case is presented to illustrate the value of the B.S.R. as a criterion for further clinical investigation. If this test had not been done the patient would certainly have been dismissed with a clean bill of health and the tumor allowed to become well advanced. When the B.S.R. is elevated, even in the absence of any clinical evidence of disease, further investigations should be carried out to determine the real diagnosis.

METHOD OF REPORTING MASS X-RAY SURVEYS

By Connecticut State Tuberculosis Commission

ALAN L. HART, M.D., *Hartford*

EACH year reports are sent by the State Tuberculosis Commission to practicing physicians in Connecticut concerning from 1,500 to 3,000 persons examined in mass x-ray surveys conducted by the Commission. The methods and standards used in the making and interpretation of these films are therefore of direct and individual importance for most physicians in active practice in Connecticut.

HISTORY OF SURVEYS

The Connecticut State Tuberculosis Commission began its mass x-ray surveys in 1944. Since March 1946 two mobile x-ray units have been in continuous use the year around. From 60,000 to 85,000 persons are examined per year. Between October 1944 when this program began and December 31, 1954, some 625,000 persons have been x-rayed.

TYPES OF SURVEYS

Both community and industrial surveys are done. From time to time surveys are also carried out in the almshouses, the mental hospitals, and certain prisons. School surveys are done only under exceptional circumstances; the present low incidence of

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SUMMARY

Between October 1944 and December 31, 1954 more than 600,000 people were examined in the mass x-ray surveys conducted by the Connecticut State Tuberculosis Commission. This paper describes the standards used in interpreting these survey films and the method of reporting them. A great variety of pathological conditions is found, including not only tuberculosis but also chest tumor, pneumonitis, lung abscess, bronchiectasis, pneumoconiosis, cardiac disease, and lesions of the bony thorax.

Detailed x-ray reports on all persons with visible evidence of chest disease are sent to physicians of their own choice. Reports to physicians go out 24 hours before notifications are sent to patients to seek medical advice. In serious conditions such as "hot" tuberculosis, pneumonia, or suspected cancer, emergency reports are made to physicians, usually by telephone.

pulmonary tuberculosis among grade school and high school children in Connecticut makes such survey very unproductive. However, high school students over 15 years of age are invited to participate in community surveys on the same basis as adult residents.

LOCAL DIRECTORS OF HEALTH

The local director of health is always informed when a community survey is planned and his co-operation is solicited. His active assistance in organizing the survey is welcomed and is urgently requested in the follow-up of persons believed to have tuberculosis. At the conclusion of a survey, a statistical summary is sent to the director of health together with copies of the x-ray reports on all chest films thought to indicate pulmonary tuberculosis.

STANDARD PROCEDURES

The standard rate of operation is 50 people examined per hour, or 300 per working day. This rate is easily maintained, without haste or confusion.

All films made in the mobile units are stereoscopic 4" x 5". For three years (1946-49) 70 mm. films were used on a trial basis. They were abandoned after careful review of 25,000 routine survey films showed that significant chest lesions were missed four times more often on 70 mm. films than on stereoscopic 4" x 5" films. Our experience over a ten year period is that an experienced roentgenologist will pick up as many, or perhaps more, chest lesions on stereoscopic 4" x 5" as on single 14" x 17" films and will have, in addition, the help of stereoscopic observation in locating the lesion.

CRITERIA FOR REPORTING PULMONARY TUBERCULOSIS ON SURVEY FILMS

1. Definite shadows, localized on stereoscopic films as intrapulmonary, are visible.
2. These shadows may be:
 - A. Nodular: (a) soft, poorly defined, mottled; (b) hard, discrete, sharply outlined.
 - B. Mixed nodular and linear.
 - C. Mixed nodular and cavitory.
 - D. Mixed nodular, linear, and cavitory.
3. These shadows are at least partly in the upper half of one or both lung fields.

Tuberculosis or suspected tuberculosis is not reported when

1. Intrapulmonary shadows are purely linear in character, or
2. Intrapulmonary shadows are entirely basal in location.

CRITERIA FOR REPORTING SUSPECTED CHEST TUMOR

1. Definite discrete nodular shadow, localized on a stereoscopic film as intrapulmonary, is visible in the lung field.
 - A. If these shadows are multiple, they suggest either (a) benign lesions, such as hematoma, or (b) malignant metastases.
2. Definite nodular shadows in one or both hilums.
3. Areas of atelectasis, frequently extending out from the hilum.
4. Areas of increased translucence in the lung field, without other visible cause, and suspected of being due to obstructive emphysema.

READING SURVEY FILMS

The first scanning of survey films is done by a physician who has not only had special training and long experience in reading chest films but extensive clinical work in tuberculosis.

Whenever a suspicious film is found, the master file in the Tuberculosis Commission office is checked for other data concerning the individual involved. Is he a previously known case of tuberculosis? Has he been a patient in one of the State tuberculosis hospitals? Has he been x-rayed in a previous survey or seen in a field clinic? Has a report been made on him by a practicing physician, a local health officer, a local public health nurse, or the Veterans' Administration? If so, his name will appear in the file and all available information will be promptly assembled. Chest films made elsewhere will be borrowed, if possible. Previous films made by the Tuberculosis Commission will be in our files if they were positive for chest disease; previous negative films made by the Commission will still be in our files unless they were made over seven years before.

All available data and all previous chest films which can be located are used by the survey physician in making his report. He may be able to state that a pulmonary lesion has existed without visible change for — years, or that a lesion has appeared in an area where none was visible at a definite earlier date, or that a lesion previously noted has progressed since that examination. In the report are incorporated the x-ray impression, a summary of all available data

about the patient, and recommendations for further study.

When the x-ray findings suggest a serious, immediately hazardous condition, such as pneumonia, carcinoma, or "hot" tuberculosis, an immediate report by telephone or letter is made to the family physician and by letter to the patient. But normally all positive reports of a single survey are mailed at once. The reports to physicians precede by 24 hours those going to the individuals x-rayed. The reports to individual patients do not name the disease suspected but urge them to see their physician at once.

Reports on apparently normal chests are also mailed to all persons x-rayed. These go only to the persons examined, unless there is a specific request for a report to the family physician also. Nothing would be gained by burdening doctors with numerous reports of normal chests.

STORAGE OF SURVEY FILMS

Films showing apparently normal chests are kept in storage for seven years before being destroyed. No card index by name is made for these films because of the great volume of clerical work involved, but these films can be quickly located if the following information is furnished: correct name, sex, approximate age, the survey in which the patient was examined and its approximate date.

Survey films showing visible disease of any sort are kept in separate positive files, with an up-to-date alphabetical card index. Any given film can be quickly located if the patient's correct name is given.

These films are available on a loan basis to physicians, clinics, and hospitals whenever needed in subsequent examination of the patients concerned. Their return is requested in all cases, so that they may be available for reference again if needed.

FOLLOW-UP

All pathological conditions found on survey films are reported with equal care, but in the case of suspected tuberculosis a persistent follow-up is instituted. The private physician, the local director of health, the local public health nurse, and the consultant public health nurses on the Commission staff are all concerned in this undertaking.

In addition, Consultation Service clinics are now operated by the Tuberculosis Commission in 14 areas where local chest clinics do not exist. Patients

are examined in the Consultation Service only on referral by their own physicians, and complete reports of the findings are sent directly to these physicians. No charge is made for this service.

VARIETY OF CONDITIONS FOUND

The primary purpose of the survey program of the State Tuberculosis Commission is, of course, to find the hitherto unknown case of tuberculosis, but a great variety of other conditions is also discovered. For example, in 1951 549 persons and in 1952 461 persons had some cardiac abnormality, that is, visible change in the shape or size of the heart shadow. For the most part the cardiac conditions found are those due to rheumatic fever or hypertension and arteriosclerosis.

Many nontuberculous pulmonary lesions are also picked up. In 1953, for example, 236 persons had x-ray evidence of pneumonitis, lung abscess, or bronchiectasis.

Of great importance are the chest tumors discovered in surveys. Up to December 31, 1952, 284 persons were found to have either parenchymal or mediastinal masses. In 1953, 84 persons were reported as having suspected chest tumors; in 1954, 122 persons were so reported. In a gratifying number of these patients prompt surgical treatment has resulted in apparent cure.

The number of cases of pulmonary tuberculosis fluctuates from year to year but averages nearly 500 annually. During the calendar year of 1954, 466 persons were found with definite x-ray evidence of tuberculosis. Of these 195 were new cases, previously unreported. The remainder were already known cases, re-x-rayed for comparison with previous chest films.

PURPOSES OF MASS SURVEYS

The mass x-ray surveys conducted by the Connecticut State Tuberculosis Commission are carefully planned and conducted in order to

1. Discover the unknown cases of tuberculosis in the State, thus reducing the danger of infection being passed on to their families and associates and, at the same time, giving the patients the best possible chance of recovery.

2. Give all possible aid to the physicians of the State in the early discovery and diagnosis of nontuberculous chest disease, particularly tumors of the lung and mediastinum.

THE WEST HAVEN VETERANS ADMINISTRATION HOSPITAL

A Community Mental Health Resource

EUGENE B. BRODY, M.D., *West Haven*

THE Neuropsychiatric Service of the new Veterans Administration Hospital in West Haven opened on September 10, 1953. This gave the greater New Haven area its first psychiatric inpatient facility capable of serving a large section of the community. The aim of this report is to present data from the first year of operation which indicate that the Service, although a unit of a federally supported hospital, is making progress in meeting local needs and is functioning as a major community mental health resource.

1. OPERATIONS AND STAFFING

During the current year the staff of the Neuropsychiatric Service includes six senior and thirteen resident psychiatrists, one neurologist, four psychologists, including one working primarily on neurophysiological research, two psychological trainees, and two part time volunteer psychologists. All staff members, except those in a training status, are members of the faculties of the Yale Departments of Psychiatry and Psychology and the residency training program is under the general supervision of the Yale Dean's Committee. There are five consulting and two attending psychiatrists. During the next year the number of residents will be increased to seventeen and it is expected that there will be one additional staff and four additional trainee psychologists.* All third year Yale medical students have a six weeks clinical clerkship on this Service.

2. SOURCES OF PATIENTS

During the twelve months ending September 9, 1954, 609 patients were seen by the NP Service for diagnosis and disposition or admission, exclusive of intrahospital consultations from other services. More than 41 per cent of these resided in New Haven County, and by far the majority of this group were

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SUMMARY

Data from its first year of operation indicate that the Neuropsychiatric Service of the West Haven Veterans Administration Hospital is beginning to fill a serious community need for an inpatient unit offering diagnosis and intensive short term treatment, or appropriate disposition, to acutely ill psychiatric patients in the low income group. The youth of the patients and the relative prominence of character problems resistant to treatment elsewhere seem to be consequences of the fact that this is a unit of a V.A. rather than a State, and of a general rather than a psychiatric hospital. This suggests that the NP Service may make a particular contribution to the community in dealing with fathers of young children, men in their potentially most productive years, and young men in chronic conflict with society. The data so far suggest that the investment in equipment, and particularly personnel necessary to maintain a service geared to intensive psychotherapeutic treatment, may be justified by the return to the community of patients who are potentially chronic burdens to the taxpayer, whether they are cared for by federal, State or local agencies.

from greater New Haven. At least ninety per cent were from the State of Connecticut (see Table I). Of these 609 patients, 61 were seen on more than one occasion or were readmitted one or more times. Where admission was not feasible because of lack of beds, the NP Service functioned as a diagnostic and disposition center, returning patients to the care of their families, local physicians, or when necessary

*As of the time of publication these changes have been accomplished.

sending them to State hospitals. The demand for this essential community service has highlighted the need in the New Haven area for a hospital equipped to offer diagnosis, intensive short term treatment, or appropriate disposition of acute psychiatric patients.

TABLE I
HOME COUNTIES OF 609 NP SERVICE CONTACTS
September 10, 1953 - September 9, 1954

	PER CENT
New Haven County (including 33.8 per cent from greater New Haven).....	41.5
Fairfield County	21.5
Hartford County	16.4
Litchfield County	2.7
New London County.....	2.0
Middlesex County	1.9
Windham County9
Tolland County8
No home address.....	5.9
Out of State (including 2.4 per cent from Massachusetts)	5.9

Thirty-five per cent of the patients were referred to the hospital by their families, by unidentified sources in the community, or came on their own initiative. Referrals by V.A. sources accounted for 29 per cent of the total, and 23 per cent came from private practitioners. The remainder were referred by publicly supported clinics in the State or by non-medical sources such as the clergy and the courts. As the hospital becomes better known in the community the number of referrals from social and municipal agencies should increase.

3. WHO ARE THE PATIENTS?

As expected, the great majority of veteran patients are men. A striking feature, however, is the youth of the patient population. Sixty-eight per cent of the first 130 consecutive open ward psychiatric admissions who remained for at least seven days (exclusive of neurological patients and intrahospital transfers) were 34 years of age or less. This continuing trend, which is identical with that on the acute closed ward, has important implications from the community mental health standpoint. The young adult is the parent of the child in its most formative years. He is also in the most productive period of his life. Hospitalization for psychiatric illness is usually much more prolonged than in the case of other diseases. If treatment is not successful, the patient often remains in a hospital (except in the case of suicide) during the years when he might be

a contributing member of society. He is thus a double burden to his community.

Approximately 75 per cent of the patients were veterans of World War II, and the Korean War accounted for 21 per cent. Many young veterans of both recent wars had achieved no stable adult role before entering the service and are in particular need of psychotherapeutic help aimed at their eventual reintegration into the community.

TABLE II
DIAGNOSTIC CATEGORIES OF NP PATIENTS
September 10, 1953 - September 9, 1954

	(609) CONTACTS PER CENT	(332) ¹ ADMISSIONS PER CENT
Schizophrenic reactions	25.6	28.7
Neurotic reactions (anxiety).....	19.0	16.4
Depressive reactions ²	6.6	6.6
Other neurotic reactions.....	8.7	12.4
Character disorders	12.3	19.9
Alcoholic states	6.9	2.2
Possible CNS disease ³	5.7	7.4
Unclassified by label.....	5.2	0.0
Seizure states	5.1	3.3
Other psychotic reactions.....	4.8	4.1

1. This number includes 24 readmissions of 18 individuals. Since 15 charts were unavailable for tabulation because they were out to other hospitals, the percentages in the table refer to 317 admissions.

2. A clear differentiation between psychotic and neurotic depressive reactions was not always made prior to admission and investigation. This refers to presumably nonpsychotic depressions.

3. Most neurological problems were seen by medical residents and admitted to the Medical Service (under the supervision of the neurologist) and are therefore not represented here. Those admitted to NP were primarily diagnostic problems or patients with significant personality disorders.

Table II compares the diagnoses of the total group of patients seen with those who were admitted. Both reflect the relatively high incidence of schizophrenic and severe anxiety reactions in psychiatrically disturbed young men. Most patients seen because of alcoholic states were treated without being admitted. The most noticeable difference between the two groups is the greater percentage of primary diagnoses of character disorder (or immaturity reaction) in the admitted group (after hospital investigation). The presenting complaints of patients with character disorders included neurotic symptoms, pronounced emotional lability, psychotic-like episodes, aggressive or antisocial behavior, and sexual deviations as

well as alcoholism. The impression that character disorders are relatively prominent in the group of psychiatrically disturbed veterans is substantiated by the finding in the survey of the initial 130 admissions that the use of alcohol, although not a primary problem, was listed as a "symptom" in 53 per cent of the cases. That these individuals contribute more than their share to the burdens of community law-enforcing agencies is suggested by the fact that more than 27 per cent of the 130 have had recorded difficulties with the law; more than 10 per cent have served jail or reformatory sentences; more than 26 per cent received punishment while in the Armed Services for disciplinary infractions such as AWOL.

Although there were many exceptions, the level of individual and community achievement tended to be low. Of the survey group of 130, at least 56 per cent had not finished high school; over 50 per cent were single, divorced, or separated; over 52 per cent had attained only the rank of private first class or less during their military service. Only slightly more than one-third of the group were regularly employed at the time of their admission to West Haven. Over 46 per cent of them fell into the category of essentially unskilled labor.

There was an impressive incidence of serious emotional difficulties prior to the present hospitalization. Almost 52 per cent of the 130 patients had had some previous outpatient treatment for problems related to their present complaints; 40 per cent had had psychiatric hospitalization while in the service; and over 61 per cent had had previous civilian (including V.A.) psychiatric hospitalization. A total of 73 per cent had had some previous psychiatric hospitalization.

These data reveal that a significant number of the admitted patients are those who have not benefited from other community resources, and area drain upon the community. They have responded poorly to previous treatment; they cannot afford private hospitalization; they are usually not committable except for brief periods or refuse admission to State hospitals because of fear or social stigma; they are generally refractory to outpatient therapy which does not supply the necessary control and support. The V.A. hospital provides a source of help for this group and psychotherapy in a hospital setting has proved effective in many instances.

4. WHAT HAPPENS TO PATIENTS WHO ARE ADMITTED?

The first section of the NP Service which was activated on September 10, 1953 was a 30 bed open

unit. An additional 36 bed open unit was placed in operation a month later, and a 16 bed, locked unit (with 4 additional isolation rooms) was activated on April 20, 1954. A 36 bed combined psychosomatic and neurological unit and another 16 bed, locked unit remain to be opened.* In November, 1954 an 80 bed unit was added for chronic psychotic patients transferred from two large NP hospitals in the New England area. These patients will be investigated with the aim of identifying the factors contributing to their prolonged hospitalization (up to 25 years in some cases), and of arriving at techniques of treatment and rehabilitation of chronic patients.

a. *Treatment*—Aside from the last unit mentioned, which will, for the time being, be considered as a special division of the NP Service, the goal for every patient has been definitive treatment with the aim of eventual return to the community. With this in mind, every patient, including those receiving physiological treatments, such as electroconvulsive therapy or subcoma insulin, is involved in an individual psychotherapeutic relationship. Psychotherapy, even where support is the major goal, utilizes uncovering techniques to some extent aimed at insight and emotional reliving of significant events. At the present time interpretation of transference phenomena is used as a major therapeutic tool in most, although not all, cases.

Individual therapy is supplemented by programs of group psychotherapy, and the various activity therapies involving creative, industrial, manual and artistic work, supervised group recreation, and the other adjunctive activities usually found in psychiatric hospitals. A "patient-government" program involving a parliamentary organization of patients provides a stimulus toward maturation and increasing assumption of personal responsibility.¹ Whenever possible patients in later stages of hospitalization may begin their gradual reintegration into the community by working during the day while returning to the hospital at night. Other patients do useful work in the hospital (called hospital industry) as a form of occupational therapy.

b. *Length of stay*—The length of hospitalization is usually longer in cases of psychiatric disability than for other medical problems. In addition, certain

*The second locked unit was activated in July, 1955. At the time of publication the average daily census of the locked services usually approaches 40, since the demand for beds is so pressing that isolation rooms are often used as bedrooms.

patients are reluctant to leave an environment which provides reasonably pleasant, secure living conditions at no expense to them. This may be particularly impressive when the patient feels that the doctor who recommends discharge from the hospital is unmindful of his (the patient's) privileges as a veteran. In some instances it is clear that the patient's status as a veteran makes psychotherapy more difficult, particularly in dealing with problems of dependency and ambivalence to authority.

Statistical evaluations of length of hospital stay are difficult to make when a unit has not been in operation sufficiently long for all patients admitted during the period under study to have been discharged or placed on a "chronic" status. Table III shows the length of hospital stay of patients admitted from September 10, 1953 through September 9, 1954. At the time of computation (December 15, 1954) 32 of the group admitted during the first year remained in the hospital. Eight of the group of 32 patients were admitted in the last month of the one year study period, 21 had been hospitalized for between one and nine months, and three for nine months or longer. Although average figures tend to be somewhat deceptive, the mean period of hospitalization for the first year of operation, 78.3 days, and the median of 56 days, compare favorably with our impression that from 60 to 90 days of hospital treatment are usually required before the "average" patient who responds to brief intensive psychiatric treatment is ready for discharge. Table III shows that 67.8 per cent of all admissions were 90 days or less in duration.

TABLE III

LENGTH OF HOSPITAL STAY (AS OF DECEMBER 15, 1954) OF 317
NP ADMISSIONS
September 10, 1953 - September 9, 1954

NUMBER OF DAYS	PER CENT
1 - 30	30.9
30 - 60	22.4
60 - 90	14.5
90 - 120	8.5
120 - 150	7.9
150 - 180	5.9
180 - 210	3.2
210 - 240	2.5
240 - 270	.6
270 - 300	1.9
300 - 330	.3
330 - 360	.3
Over 360	.9

TABLE IV

DISPOSITION (AS OF DECEMBER 15, 1954) OF 317 NP ADMISSIONS
September 10, 1953 - September 9, 1954

	PER CENT
Discharged, maximal hospital benefit ¹	73.5
Discharged, against medical advice ²	10.7
Remaining on NP Service.....	10.1
Transferred to State or VA NP hospitals for chronic locked ward care.....	4.1
Administrative discharge9
Remaining on non-NP wards.....	.6

1. This also includes those on trial visit and leave of absence as well as three discharged to family care placement.

2. This also includes patients who left the hospital without being officially discharged and did not return. These were technically on an "AWOL" or "elopement" status. There were two suicides and one other death of patients on elopement status.

Table IV gives data as to the disposition of patients admitted during the year ending September 9, 1954. The tabulations were made on December 15, at which time 10 per cent of them remained on the Service.

The data referring to length of stay and disposition include findings on both open and closed wards. Since most closed ward patients are transferred to an open unit before discharge, this gives a reasonable approximation of the activity of the entire Service. Table V shows the activity on the locked unit during its first eight months of operation. The number of admissions and discharges reflect both the pressure from the community to admit acute psychotic patients, and our policy of engaging acute psychotics in intensive psychotherapy and moving them to an open unit whenever feasible.

The major impression gained from the data presented in this section is that an active service geared to the intensive psychotherapeutic treatment of patients with psychotic and character disturbances as well as the neuroses can probably be justified in terms of the investment in personnel and equipment which is required. This type of service may ensure the rapid return to the community of many patients who might otherwise remain as chronic burdens to the taxpayers, as well as noncontributors to their families and the community at large.

5. THE PSYCHIATRIC SERVICE IN A GENERAL HOSPITAL

As the intraservice problems and the purely psychiatric functions of the NP Service have become stabilized it is gradually increasing its useful-

TABLE V
MOVEMENT OF ACUTELY PSYCHOTIC PATIENTS
Activity on the 16 Bed, Locked Unit (opened April 20, 1954) During the First Eight Months of Operation

MONTH	AVERAGE DAILY CENSUS	ADMISSIONS ¹	DISCHARGES ²
1954			
May	14	14	6
June	14	15	16
July	16	14	13
August	16	5	5
September	15	4	9
October	16	13	9
November	17	10	12
December	16	6	7

1. Admissions to this unit came by transfer from open units of the NP Service and from Medicine and Surgery as well as directly from the community. These figures do not include overnight "sleepers" who were usually admitted to the seclusion area (four beds in addition to the 16 listed above) to tide over brief periods of severe agitation. They do include scheduled returns from leaves of absence (similar to trial visits).

2. Most of these figures represent transfers of patients to open units, although some patients were discharged directly to the community. They also include patients departing for leaves of absence.

ness to the Medical, Surgical and Tuberculosis Services and thus to the community at large. During the year ending September 10, 1954 the Psychosomatic Section of the NP Service saw 190 patients in formal consultation on other units. Current data suggest that the figure for the second year will be between 250 and 300. This section is staffed by a senior psychiatrist and two advanced residents and utilizes the services of cooperating personnel such as psychologists and social workers in the same manner as the other sections of the Service. With the participation of psychiatrists in medical rounds and conferences, it is expected that there will be a gradually increasing and continuous exchange of views on all matters relating to diagnosis, treatment and clinical administration, so that the number of formal consultations will only indicate one aspect of the functioning of the Service in relation to the hospital as a whole.

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PLAN TO ATTEND THE AMA
CLINICAL SESSION IN BOSTON
NOVEMBER 29 - DECEMBER 2, 1955

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

The Annual Diabetes Detection Drive

We welcome Diabetes Week once again, this year on November 13 to 19. With it comes re-emphasis on that metabolic disease of endocrine origin to combat which so much has been accomplished since the discovery of insulin. As every physician is aware, diabetes "primarily involves carbohydrate metabolism but also affects the metabolism of protein, fat and minerals. It results from a deficiency, either absolute or relative in the supply of insulin from the islands of the pancreas. This deficiency, however, may be modified by the activity of other endocrine organs (including the pituitary, the adrenals, the thyroid and the liver). The disorder is manifested by hyperglycemia and glycosuria and tends to lead to malnutrition, ketoacidosis and complications affecting the arteries, peripheral nerves, eyes and kidneys."¹

One has only to listen to that veteran of many diabetic wars, Elliott P. Joslin, to appreciate what a large part education of the patient plays in his treatment. Dr. Henry B. Mulholland in his presidential address before the American Diabetic Association last June emphasized the importance of education of both the public and the patient.

"By far the most important and briefly shining star in our horizon is the patient, whose physical welfare is paramount. Because of this, in broadening our scope, much concern has been given to this phase of our activities.

"The lay magazine, *ADA Forecast* . . . is a

real achievement. The magazine has over 30,000 subscribers, has a special Canadian Edition, and its contents are copied and translated by other diabetic publications in many foreign countries.

"Dissemination to the diabetic of useful and accurate information through this source is vital. Another effort of great importance to diabetics and their families is the annual Detection Drive. To be sure, detection is important, but the greatest good is accomplished as a result of the widespread public interest aroused in diabetes during Diabetes Week.

"Unlike other health groups, we have made no direct appeal for funds. Emphasis is laid on the effort to search out those with this condition in its early stages. This is a very sound principle because, in so doing, early treatment may prevent disastrous complications later on. Even more significant perhaps are the educational aspects which sensitize the general public as well as the diabetics to the importance of diabetes and the part it plays in the welfare of the people in every community."²

When one considers the difference in the treatment of the diabetic now and 25 years ago one is impressed. In particular the problem of the young diabetic is a challenge to the physician.

"The impact of the diagnosis of diabetes on a youth may be shocking. He discovers that a certain amount of freedom of action to which he had grown accustomed must suddenly be denied. With education and training, he is led to realize that he is straddling a fence on which he must learn to stay.

If he fails to learn his balance act quickly and well, he may fall to one side or the other. His adjustment to this situation is gradual, requiring almost constant attention at first, but in time becoming automatic.

"Thanks to recent discoveries, the diabetic in this situation can safely be permitted much more freedom than was possible a generation ago. Immunization technics and antibiotics have removed many of the hazards of infection. Practical application of the general rules of nutrition has liberalized diet restrictions. A variety of insulin forms has reduced the annoyance of frequent injections for many. The survival of large numbers of young diabetics for ever increasing spans of a reasonably normal life has helped to remove the fears of complications that formerly haunted these people."

However, there exists always the anxiety due to these complications but just how these anxieties should react is best expressed by Dr. William B. Kennedy³ in the following words:

"The complications of diabetes pose an ever increasing problem to the young diabetic, and thorough education about his disease that is essential for his adjustment to it paradoxically exposes him to the knowledge of pending complications and the natural fears that are bound to come. Even the most stalwart young patient finds it difficult to express all anxieties about his future. To a certain extent these fears can be transformed into a stimulus toward cooperation and control. However, tension and anxiety over any situation are likely to interrupt a smooth diabetic course and to offset benefits that might otherwise come from this reaction. An optimistic attitude is essential here. The doctor, parents, and others in contact with the diabetic must avoid exhibition of these same fears. Even an exaggerated display of hope is perfectly justified. Complications that can be avoided, treated, or compensated for must be handled expertly by both the patient and those assisting him. Those for which we do not have effective preventative or therapeutic devices are best ignored. The diabetic is likely to learn to develop this attitude if allowed to do so."

Whether or not you are a diabetic, have a diabetic

in your home, or treat diabetics, you should lend your wholehearted support to the Diabetic Detection Drive. That new diabetic must be discovered and assisted in his desire to live as healthy and happy a life as possible.

Progress of Cornell Crash Injury Research

Physicians of Connecticut have been cooperating with the Cornell Crash Injury Research project for more than a year and tangible progress can now be shown. Mr. John O. Moore, who has been in direct contact with the Connecticut program, has succeeded Mr. Hugh DeHaven as director and has written to the executive secretary concerning the recent progress in automotive design that has been based upon results of the Cornell research. It is evidence of the value of the data that Connecticut physicians in hospitals have provided.

"Because your organization has undertaken an Automotive Crash Injury Research program jointly with Cornell University Medical College, I feel that you should know that the valuable work accomplished has been a vital factor leading to the incorporation of safety design features in Ford, Chrysler and Studebaker 1956 products which are specifically engineered to protect automobile occupants if accidents happen.

"The excellence of data developed in your State, matched with similar information from seven other cooperating States, has enabled Cornell University Medical College to produce reliable statistical information which Automotive manufacturers have put to immediate use. The practicability of the Interstate Automotive Crash Injury Research plan has thus been clearly established.

"Findings produced by this interstate project have identified the most frequent causes of injury in passenger automobile accidents as ejection from doors which open (doors which have opened as a result of impact on some section of the car other than the door itself); contact with instrument panel; contact with windshield and header strip; contact with steering wheel and steering components; and contact against door structures. The establishment of this order of dangerousness has led to recent announcements by Chrysler and Ford that seat belts are to be offered as optional equipment in their products. More recently, in advance information concerning 1956 models, the Ford Motor Company announced that it will offer a new type door latch

¹Frank N. Allen, M.D., *Internal Medicine, Its Theory and Practice*. Lea & Febiger, Philadelphia, 1951.

²Diabetes 4:4 July-August, 1955.

³William B. Kennedy, M.D. *Psychologic Problems of the Young Diabetic*. Diabetes, 4:3 May-June, 1955.

designed to keep doors closed under crash conditions, a steering wheel which has been engineered to absorb impact energy and which should represent a reduced injury potential to the chest, and an optional installation of padding for the instrument panel which should effectively eliminate many injuries and reduce the severity of others.

"These developments represent the first major steps taken to make available to the public an automobile which has been scientifically engineered and dynamically tested for the control and reduction of injuries to occupants in accidents. This rapid use of data taken from your highways and submitted to Cornell has documented the need for these design changes.

"We feel that the fact-finding role played by individuals in your organization in the sampling areas is one that may be looked on with pride by all the citizens of your State.

"We would appreciate it greatly if you could make the contents of this letter known to all who have participated in this important research effort."

Occupational Aid for the Retired

Executives in industry today are faced with a major problem in retiring senior employees. Those who have had experience in finding profitable occupations for this group believe that the transition from employment to retirement should be a gradual process with the employees participating in various selected activities. Very few localities offer opportunities for such selected activities on an organized basis.

Connecticut and the Hartford area in particular are fortunate in having access to such an organization known as Avocationers, Inc.* Avoco, as it is called, was established in 1947 and is a private operation designed to assist and prepare groups and individuals for happy retirement through planned work and recreation. Believing that the date of birth alone is no barrier to an interesting and active period of life in later years, this organization is aiding men and women to anticipate and train for vocational age changes. Its program is varied and includes planning and arranging educational, occupational and recreational programs. The occupational program includes teaching various arts and crafts, creative designing, merchandising, and maintenance of buildings, equipment, tools and machines.

There is no lack of material for use in these programs. The need is for more of our citizens to realize the opportunities offered by Avoco and thus make possible a larger enrollment of the older age group who have retired or face this step in the near future. Physicians, especially those who engage in general practice and particularly in geriatrics, can advise their patients of this unusual opportunity to make their later years profitable and enjoyable.

Funds have been supplied to a limited degree but, like so many other activities, if increased in proportion to the need would make Avocationers, Inc. a more potent factor in the life of the community. Memberships ranging from a mere token in cost to an almost unlimited figure provide one very tangible means of support.

Because retirement is becoming a factor of increasing interest to the medical profession, methods of making it a profitable and happy period in life such as the above organization offers should receive encouragement and support from our readers.

Thomas T. Mackie, M.D.

For the second time in its brief existence of almost twenty years the Editorial Board of the JOURNAL has suffered the loss of one of its valuable members by death. The first was Paul P. Swett who so courageously, in spite of his physical handicap, produced each month the column entitled "From Our Exchanges." This time it is Thomas T. Mackie of Westport, a nationally recognized authority on tropical diseases. Dr. Mackie recently returned from Surinam, the former Dutch Guiana colony in the Caribbean, and in his report to that government recommended the establishment of an international center for research and field work in tropical medicine at the capital, Paramaribo.

Dr. Mackie had held many positions of distinction, serving the Secretary of War, the State Department, the U. S. Army, the National Research Council, and the U. S. Public Health Service. He was an active member of the Editorial Board, having contributed from his own pen and given freely of his advice. On the day of his unexpected death the editor received a short note from him graciously accepting an offer to write an article for the JOURNAL based on his recent visit to Surinam.

The JOURNAL extends its deepest sympathy to the bereaved widow and to their children.

*42 Allyn Street, Hartford, William W. Leonard, Managing Director.

The American Medical Education Foundation Reports

Total contributions to the Foundation during 1954 amounted to \$1,181,928.63 which represents an increase of \$91,966 in dollar income over contributions received during the previous year. Contributors to the Foundation increased from 18,176 in 1953 to 22,996 in 1954—a gain of 4,820 new contributors to the AMEF program.

SOURCE OF GIFTS	MEDICAL SOCIETIES				TOTAL	DISBURSED TO NATIONAL FUND
	A.M.A.*	PHYSICIANS	AND ASSOCIATIONS	LAYMEN		
1951	\$ 500,000	\$ 91,392	\$151,503	\$3,072	\$ 745,967	\$ 640,682
1952	500,000	291,478	113,232	1,842	906,553	777,019
1953	500,000	467,217	118,200	1,957	1,089,962	1,044,602
1954	500,000	507,551	170,687	811	1,181,928	1,101,578
Totals	\$2,000,000	\$1,357,638	\$553,622	\$7,682	\$3,924,410	\$3,563,881

*In addition to a substantial grant each year, the American Medical Association underwrites the total operating cost of the Foundation's promotional and administrative program. This is done so that every dollar contributed may be passed on to the medical schools without the withdrawal of operating expenses.

The Foundation's income record above indicates a strong increment of individual support . . . the individual physician in America is more aware today than ever before of the financial needs of medical education and the dangers to our educational system if private support fails to produce the needed funds.

The Foundation now has 53 State and metropolitan committees working tirelessly to help attain the annual goal of \$2,000,000. State and local committee memberships are made up of practicing physicians who feel that the financial problems of the medical schools can best be solved by the combined efforts of the profession in channeling philanthropic funds into the medical schools through the Foundation.

Not all States operate large, active committees; several have increased the state medical society dues and allocated a portion of the increase to AMEF; others have given substantial treasury grants to the Foundation. During 1954, the Foundation received outstanding support from the California Medical Association which donated a treasury gift in the amount of \$100,000 to aid the program. Illinois and Utah physicians supported AMEF through the dues increase system or Illinois plan, whereby a stipulated amount of their state medical society dues was turned over to the Foundation. Substantial treasury gifts based on membership were also contributed by

the state medical societies of Arizona and Iowa. Treasury gifts were also donated by the Medical Society of Virginia and the Massachusetts Medical Society.

In the list of State Society member contributions Connecticut figures are as follows: Number of contributors—AMEF 381; alumni 1,026; total 1,407. Amount of contributions—AMEF \$12,862.50; alumni \$26,485.16; total \$39,347.66.

For 1954 Connecticut appears on the honor roll of States both in participation percentages and in highest income. This is not an occasion for any great rejoicing when it is noted that less than one-half the membership in the Connecticut State Medical Society are contributing anything to the support of their medical schools.

How Does a Profession Differ From a Trade?

One plies a trade but practices a profession, and yet when an attempt is made to define the difference between the two he is at once perplexed. There are several reasons why it is difficult, if not impossible, to draw a hard and fast line between a business or trade on the one hand and a profession or calling on the other. One difficulty lies in the fact that even professional men: ministers, teachers, lawyers, doctors, cannot completely ignore the financial aspect of their callings. Like other folk, they marry and most likely have children whom they must raise and educate. The old family doctor of tradition, ever ready for a call and careless about billing his patients, still exists. This type is not as extinct as the dodo, particularly in some remote country districts. Then again the number of so-called professions has multiplied apace. In the nineteenth century the term "the learned professions" was commonly applied to the

ministry, law and medicine. There was a sort of implied assumption that one did not go into these occupations, particularly the ministry, unless one had a "call," i.e., a mysterious and rather vague term which indicated a special frame of mind which impelled its possessor toward a particular profession. As a matter of experience, there is little question that men go into any profession for a variety of reasons. The use of the term learned professions, as applied only to the ministry, law and medicine, has become a misnomer, for there are plenty of learned engineers, learned architects, learned nurses, learned professors, and so on almost ad infinitum. The main difficulty, we suspect, is that the difference between a business and a profession is the spirit in which it is undertaken and it is hard to define such an abstract quality. A doctor may conduct his practice like a trade and a tradesman may inject the spirit of a profession into his business. Perhaps the gist of the thing can best be illustrated by examples. Let us consider Dr. X, a well trained young surgeon. His office is well organized, and there is nothing unethical about that; except in the face of emergencies he meets his patients pretty promptly; he treats them with courtesy and understanding, advises them with judgment, does not operate unless there are clear indications, does not gyp them by splitting fees or accepting rebates, is always willing to discuss the size of fees, and, when he sends his bill, he takes into consideration their financial status. Or let us take Dr. Y, perhaps equally well trained and efficient but with a decidedly different outlook. Aside from the financial end his office may be run in a haphazard fashion, his patients may wait to see him for hours, or he may be prompt and businesslike. He is probably a smoothie, advises operations when they are not needed, charges all he thinks the traffic will bear, and doesn't hesitate to split fees and accept rebates at his patient's expense.

Obviously the difference between the two men is an ethical one. X is governed by the spirit of service, he treats his patients like human beings and makes allowances for their well known frailties and for their financial difficulties. Y may also be a good psychologist and may give satisfactory service, but his chief thought is for the almighty dollar. While perhaps outwardly smooth he is inwardly hard boiled, and he resorts to the "tricks of the trade" which are not confined to trades, but have also been developed in professions. So, after all, the difference between a business and a profession seems to be mainly an individual point of view: the true

physician, while not ignoring the financial aspects of his work, is dominated by the spirit of service, while the false one, though often efficient, is dominated by the spirit of gain. As Osler said, "the two chief aims of man are to get and to beget."

G. B.

James S. Stevenson — Medical Statesman

On September 11, 1955 Tulsa, Oklahoma bade farewell to one of its leading physicians. Not only will the death of James S. Stevenson be keenly felt in his own city but the Oklahoma State Medical Association and American Medicine have lost a faithful and valuable worker.

Jim Stevenson was a friend to many. Of a kindly disposition, his advice was sought by many and his leadership recognized afar. It was due in a large measure to his support and encouragement that the State Medical Associations were able to convince the American Medical Association that the Cooperative Medical Advertising Bureau needed reorganizing with a better representation from the various State medical journals. Jim Stevenson was president of his State Medical Association in 1943 and for the following eleven years served in the AMA House of Delegates. He was missed at the 1954 Clinical Session in Miami when his fatal disease prevented his attendance, and again at the 1955 Annual Session in Atlantic City.

The JOURNAL pays tribute to the memory of this sterling medical statesman whom it was a privilege to count as a friend.

The Male Nurse Joins the Armed Forces

When President Eisenhower signed the Bolton bill on August 9 it provided commissions for qualified men nurses, and other medical specialists, as officers in the reserve corps of the armed forces' nursing or medical specialists' services. This represents an amendment to the Army-Navy Nurses Act of 1947 and is hailed by the American Nurses Association as "another milestone in the development of our military nursing services."

Legislation to provide for the appointment of men to the military nursing services has been before Congress for many years. In two world wars male nurses served their country as best they could, but not as nurses. We agree with ANA that the new legislation comes as a solid achievement which is in the best interests of the public and the nursing profession.

PROGRESS IN CLINICAL MEDICINE

PROGRESS IN THE TREATMENT OF SCHIZOPHRENIA

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THE GENERAL PROBLEM

The problem of schizophrenia, and particularly the problem of treatment of schizophrenia, is one of the most important topics of modern psychiatry. The title of this paper implies that there has been progress in this field. I would like to maintain this thesis, although I admit without hesitation that little fundamental knowledge has been added about the illness itself since the days of Kraepelin, Bleuler, and Freud. Some 25 years ago when I laid my eyes on a textbook of psychiatry for the first time, I remember that in Bumke's Textbook of Psychiatry, one of the leading German texts of its time, only half a page was devoted to treatment of schizophrenia. Now every year dozens of papers as well as good books (Hill, Diethelm) are published on this theme. There can be little doubt regarding the new interest and optimism with which we approach the challenge to treat an illness which constitutes half of the admissions to mental hospitals, fills one quarter of all hospital beds in the United States, and probably causes more unhappiness than any other illness.

Yet, in spite of enthusiasm, optimism and effort, we still have no rational, totally effective, and universally accepted method of treatment. Actually we are still in a fumbling stage in which we assume that, although we do not know what to do, we feel it is better to do something than nothing; however, I am certain that in the case of schizophrenia even such optimistic experimentation is better than pessimistic inactivity.

Evaluation of treatment in schizophrenia is very difficult. Schizophrenia is a strange illness; it is probably more than just one disease and our present diagnostic methods do not permit us yet to differentiate the cluster of diseases which we most likely lump together under one diagnosis (Redlich). Some of the experts in the field, among them the late Harry Stack Sullivan, assume that most likely we are dealing with two large groups, one an organic

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SUMMARY

The author points out that no universally accepted method of treatment of schizophrenia exists but that definite advances were made in the last decade. The two large groups of treatment used, viz., the psychotherapies and the organic treatments, are discussed.

Psychotherapy is treated in some detail and it is pointed out that psychotherapy of schizophrenics is limited by the peculiar difficulty of the method. The creation of a therapeutic community for the treatment of schizophrenia contains definite advantages over mere hospitalization.

Attempts to treat by psychotherapy should precede attempts to treat by shock therapy and lobotomy. Unfortunately, very often such a recommendation can not be carried out for socio-economic reasons. If therapy with drugs, shock treatment and lobotomy is used, it should be supported by psychotherapy and a program of rehabilitation.

group with a poor prognosis, and one psychogenic, with a good response to expert psychotherapy. Yet when we are facing the actual patient we are not able to make such a differential diagnosis. There is no doubt that prognosis in various schizophrenias differs. Catatonics have a better prognosis than paranoids and hebephrenics; unfortunately such clear differentiations are difficult to make and are mostly confined to somewhat antiquated textbooks. Yet we do know that patients with acute onset of the illness, high anxiety, obvious stresses in their life situation, a previously rather stable personality, and no evidence of schizophrenia in the family and antecedents, have a relatively good prognosis (Rennie, Cameron). The problem of evaluation, of

course, becomes even more complicated by the fact that a considerable number of schizophrenias show good spontaneous remissions; some authors think that lasting remissions may be as high as 20 per cent.

In most of the treated patients we have no means to establish whether the change is due to treatment or due to intrinsic features of the illness. In most of the published papers there have been no good controls, not because psychiatrists are not familiar with controlled therapeutic experiments, but because the complexities of the therapeutic situation in psychiatry are so great. Although we know that often the enthusiasm and involvement of the therapist is an important factor in the outcome of individual treatment or a series of treatments, we have no means of measuring this particular factor. For all these reasons, it must be quite obvious that any statement about treatment of schizophrenia must have a rather subjective coloring depending on the viewpoint of the author.

TWO GROUPS OF TREATMENT

There are two large groups of treatment used: (1) the psychotherapies and (2) the organic treatments. The psychotherapeutic approaches are based on the rationale that the central symptom of schizophrenia is a reaction of withdrawal to severe psychological trauma and that all psychological therapy must help the patient to overcome such withdrawal and isolating techniques and re-establish contact with an outside world which is less hostile and dangerous than the patient's experience has led him to assume. Such an attempt can be made in individual psychotherapy, in group treatment, or through indirect means, in a setting which we recently have termed a therapeutic community, in contrast to the less favorable milieu of the conventional mental hospital. Organic therapies, important as they have become in the treatment of schizophrenia, do not have a scientific rationale, but are empirical and often crude attempts to combat a dreadful disease. Meduna, one of the men who contributed most in this field, compared shock treatment to the kicking of a Swiss watch. It takes some despair and a lack of better methods to resort to such treatment. My own view of the usefulness of the organic treatments is not too optimistic in the acute cases, although I know that some patients have been helped dramatically by shock treatment, lobotomy, and more recently by drugs. However, I do see the greatest usefulness of the organic treatment in its

application to the chronic hospitalized patient; probably the greatest benefit of the organic treatments so far has been their impact on mental hospitals, contributing to a certain extent to a more therapeutic orientation of the hospital. Some of my colleagues, however, even doubt that.

PSYCHOTHERAPY

The psychotherapeutic approaches go back to three great men: to Sigmund Freud, who gave the strongest impetus to a rational psychotherapeutic approach to schizophrenia but personally felt pessimistic about psychotherapy and psychoanalysis of psychotics, to Eugen Bleuler and to Adolph Meyer, who were exponents of a pragmatic eclectic approach. There is a fairly large number of psychoanalytic and near analytic papers (Federn, Frieda Fromm-Reichmann, Knight, Kurt Eissler, Kubie, John Rosen, Gertrude Schwing, and others) which were reviewed in a symposium on Psychotherapy With Schizophrenics, edited by E. B. Brody and F. C. Redlich. In principle all these attempts endeavor to establish contact with the schizophrenic through understanding and acceptance, by strengthening the patient's impaired capacity for interpersonal processes through love and esteem and by making the oversensitive patient (schizophrenics are psychologically hypersensitive and not hyposensitive) capable of enduring his anxiety, guilt and shame over his primitive, destructive, and self-destructive drives. In those patients who respond to psychotherapy, reduction of their anxieties gradually enables them to abandon their most pathological defense mechanism and re-establish effective and acceptable contact with reality. Most of these techniques are not too clearly stated; some are boldly interpretative (Rosen), others less active (Federn), and there is much discussion among the authors over what appears to the nonspecialist to be unimportant technical detail. There is a strong individual and intuitive element in most reports of psychotherapy with schizophrenics and the technique is difficult to teach and to learn. In my opinion, the psychotherapist of schizophrenics must have not only a real liking for his patient (not an easy task) but a particular capacity to withstand their hostility and hypersensitivity; these qualities are possibly just as important as the therapeutic techniques in the more narrow sense. I do also believe that psychoanalytic experience greatly helps to understand the schizophrenic patient. Few therapists are capable of liking,

understanding, and helping schizophrenic patients. Fortunately this gift is not limited to psychiatrists, but occasionally schizophrenic patients and their families may be fortunate enough to find a nurse, an attendant, or a friend who at least has the personality, even if not the somewhat vaguely defined technical knowledge to help them. As psychotherapeutic contact with schizophrenic patients needs to be intensive and prolonged, psychotherapy of schizophrenia is unfortunately very costly, a serious limiting factor in its application. More recently many attempts at group treatment have been made to overcome this particular difficulty, but systematic and rational group treatment of schizophrenia has presented even greater difficulties than individual psychotherapy. Yet, thinking about group therapy of schizophrenia has led to some of the interesting newer ideas about the therapeutic milieu in which schizophrenics should be treated.

HOSPITALIZATION

Until very recently it was almost taken for granted that schizophrenics need to be hospitalized. Today, among the more progressive psychiatrists at least, there is no doubt that many schizophrenics will do much better outside of a mental hospital, provided they can stay in contact with a therapist and that some control over their environment can be maintained. This does not imply that hospitalization of limited and preferably of brief duration for purposes of diagnosis and thorough psychiatric, physical, and psychological examination is contraindicated. Actually, we believe that such an examination is very important and can probably be carried out best on a psychiatric service in the general hospital. What can and often should be avoided is prolonged hospitalization in the isolating atmosphere of the conventional public or private mental hospital. Yet certainly there will be cases where hospitalization will be indicated. The decision of hospitalization should be carefully weighed and made only if the patient is dangerous to others and to himself; if he is extremely regressed and unrealistic, and if precipitating psychological and social stresses are very severe. In recommending such a decision of hospitalization, it is important that the therapist is not motivated by his own anxiety about the problem, but by a realistic appraisal of the entire complex situation.

I believe that in most hospitals, except the very best, the atmosphere of the institution is injurious rather than therapeutic for schizophrenic patients.

This should not be construed as a sweeping indictment of mental hospitals; it is only a recognition of the atmosphere of isolation which prevails even in those institutions where human contacts are far from being harsh or crude. Actually this was recognized among others by Eugen Bleuler, Adolph Meyer, and later by Abraham Myerson who advocated what he termed total push treatment. Recognition of the importance of the atmosphere of the mental hospital in its much subtler aspects has recently been most forcefully and convincingly stressed by Stanton and Schwartz, Maxwell Jones, Caudill and co-workers, and others. Only a very subtle and sensitive recognition of this can lead to measures which will permit the schizophrenic to socialize rather than to isolate himself further. The hustle and bustle of total push treatment has been replaced in our best hospitals by meaningful interaction of patients with well trained therapeutic personnel: nurses, group workers, occupational and recreational therapists, attendants and psychiatrists. The psychiatrists in such teams may be the guiding brain and assume ultimate responsibility, but the twenty-four hour every day task will be carried mostly by the auxiliary personnel. The creation of such an atmosphere will require more than common sense; it will in part be based on understanding of the subtle complexity of the interaction with psychotic patients. It is, unfortunately, a very involved and expensive understanding and it probably will take a long time before the organizational patterns of pioneering institutions will be introduced in a significant number of public and private hospitals; and it probably will never flourish in our very large institutions. Yet at the present time I consider the creation of such a truly therapeutic community the most important factor in the treatment of schizophrenia. Such a community will provide the opportunity for therapeutically meaningful activities and relationships; it will not be as suppressive as most of our mental institutions, nor will it be, as some skeptics assume, a place of license where impulses can be acted out without restraint. The atmosphere will be one where patients actually exercise controls among each other, applying what they learn in psychotherapy and where they can be mutually helpful while pursuing the common goal of peaceful group living in the institution. Such a setting will by necessity give the patient as much responsibility in hospital activities as possible and will be much more democratic than the traditional psychiatric institutions; it will provide more contact with

the community than do most existing hospitals which are frightfully isolated.

SHOCK THERAPY

Of the organic treatments, I will limit my discussions to three major categories: (1) to the shock treatments, (2) to the lobotomies, and (3) to treatment with so-called tranquilizing drugs.

At present only insulin shock treatment and electric convulsive therapy are being used; electronarcosis is hardly employed and metrazol and camphor treatment have become obsolete. It is a comment on the difficulties which psychiatric research encounters that reports about effectiveness of these shock treatments after 20 years of use and countless such treatments vary so greatly: (Kalinowsky and Hoch) optimists report up to 85 per cent recoveries and great improvement, while skeptical observers claim there are no patients with lasting cures who would not have recovered or improved spontaneously. I do not even pretend to know the truth; but I am inclined to use shock treatments late and very sparingly. The statement that insulin shock treatment is more indicated in paranoid and hebephrenic disorders and electric convulsive treatment in catatonic disorders corresponds to my own observations.

The use of insulin treatment in most centers has decreased greatly, partly because the method is cumbersome, costly, and not without dangers, in contrast to electric convulsive therapy which is easily, all too easily, applied and, with exception of fractures, not beset by many complications. Electric shock treatment is a gruesome method of treatment, feared by most patients, and unfortunately not really successful in most schizophrenic patients. Its use in combination with various methods producing anesthesia and muscular relaxation has the advantage of decreasing the subjective discomfort and the high incidence of compression fractures of vertebrae. The use which I advocated most was to employ shock treatment as an adjuvant method of treatment, overcoming massive resistance to psychotherapeutic contact in catatonic patients, or as a method of breaking severe states of agitation. With the development of modern drug treatment, even these indications have become questionable. In any case, I would advise against prolonged and very massive shock treatment which produces cerebral impairment of an organic type, an impairment which is not always as reversible as advocates of this method

claim (Fleck and Gantt). With very rare exceptions, electric convulsive therapy should be administered in hospitals and not in a physician's office. To administer insulin treatment outside of a properly equipped hospital is outright dangerous.

LOBOTOMIES

The second major category of organic treatment is the group of lobotomies. Like shock treatment, lobotomy is an empirical therapy without any reference to etiological theory. Lobotomy, and probably shock treatment, according to work so far unpublished and carried on at Yale, reduces anxiety and tension and permits a quantitative and qualitative change in the pattern of defense mechanisms which is manifested in clinical improvement. As changes in lobotomy, particularly in the more radical methods of operation, are lasting, or at least more lasting than in shock treatment, much greater caution must be exercised in the recommendation of such a procedure. I am inclined to favor the milder operations such as anterior lobotomy and feel strongly opposed to the more massive and radical procedures. Topectomy, and later on the more minute electrocauterization with stereotactic control, as advocated by Heath and his co-workers, and by Delgado and Hamlin aroused interest; so far no convincing evidence of the superior therapeutic value of these procedures has been produced although the method has yielded much valuable neurophysiological information.

Unfortunately the argument about how useful lobotomy is, and this is true for the assessment of shock treatment too, has never been settled. John Fulton pointed to the shameful fact that after many thousands of lobotomies were carried out not a single patient has been studied thoroughly. In the meantime some interesting material has been published about lobotomized patients by the research group at Boston Psychopathic Hospital (Greenblatt, Harry Solomon *et al.*), and by A. Petrie, and a few well studied patients will be reported by E. B. Brody and his co-workers. Good statistical evaluations (B. E. Moore *et al.*) unfortunately are equally rare. Considering the indication for a lobotomy we should always keep in mind not only the mortality of the procedure (1-5 per cent), but also its possible devastating effects on intelligence and personality. One must weigh very carefully whether it is better to risk the danger of dulling some intensive human qualities or to let a patient continue in his

psychotic suffering, which some day may be cured by better and less devastating methods. Undoubtedly lobotomies have reduced the turmoil and agitation in many of our public mental hospitals, but possibly this too will be achieved by modern drug treatment in a more controlled and less dangerous fashion. Ultimately we hope that after the most flagrant psychological brutalities and abuses have been eliminated from our mental hospitals, brutal surgical and physical-medical approaches may be eliminated too and replaced by a truly humane therapeutic regime.

DRUG THERAPY

The most recent therapeutic advance in the fight against schizophrenia consisted of the introduction of two drugs: Chlorpromazine (Thorazine) and Serpasil (Reserpine); many publications about the use of these drugs have appeared within a short time (Reserpine Conference; Elkes and Elkes). Beyond any doubt both drugs, although pharmacologically very different, have a strong effect on the central nervous system. Both greatly reduce tension, anxiety, and psychomotor agitation, and have been properly referred to as tranquilizing drugs. Neither drug seems to have a specific effect on the essential process of schizophrenics, but even after a relatively short period of trial there are many observations of a beneficial effect, particularly on the agitated psychotic patient. Much has to be learned yet about the pharmacological effect of these drugs and about their relatively unknown toxic effects in humans. The fact that recommendations for dosage vary so greatly (serpasil, 3 mgm. to 60 mgm., and chlorpromazine, 15 to 200 mgm. and more) reflects an unsettled state of affairs. As application of these drugs is easy, better reports on controlled application may be expected in the near future; the ease of application, of course, enhances the danger of indiscriminate use as a panacea. Recently other medications such as cortisone and lysergic acid diethylamine in combination with mebaral have been added to the long list of pharmacaca used in the treatment of schizophrenia without any convincing evidence of benefit. However, the introduction of new, more potent, and more specifically useful drugs should be expected with some optimism.

With such an array of very different forms of treatment, the question arises as to how one should proceed with the individual case of schizophrenia. Undoubtedly any patient should have a competent

and thorough examination by a psychiatrist, assisted by his professional colleagues in the field of clinical psychology and social work. Much of the therapeutic regime will depend on the specific assets and liabilities of the individual patient and his family. Only such an examination and probably repeated and continuous evaluation will determine the important question whether the patient needs to be hospitalized or not.

Ideally, one would start with schizophrenic patients on a course of long term intensive psychotherapy by a competent therapist who has experience in the treatment of schizophrenic patients, is really unafraid of them, and likes them. During the psychotherapy the patient may be treated, if necessary, with chlorpromazine or serpasil or other medications. Such psychotherapy will have to be more flexible and broader than strict insight therapy, and the therapist or one of his associates will have to work with key members of the family and take a definite responsibility in the planning of the patient's life. Only if psychotherapy fails should organic methods, and last of them, lobotomy, be considered. I am aware that on this point differences of opinion exist; however, this is my own considerate opinion and I hope that general practitioners of medicine will consult whenever possible such psychiatric colleagues on this question who are capable of doing psychotherapy and are not opposed to psychotherapy only because they don't master it.

Based on experiences of Brody, Igersheimer, and Mohr, and more recently strongly supported by the work of Lidz and his co-workers, I am afraid that any therapy of schizophrenics which does not consider close work with key persons in the environment of the patient is doomed to fail. There are other data which bear this out quite clearly. Hollingshead and Redlich found striking differences in the prevalence of treated schizophrenics of the upper and lower social classes. In the lowest social class schizophrenia was nine times as frequent as in the two upper social classes. Searching for an explanation of this striking difference, it was found to be due to an accumulation of chronic schizophrenics in the lower classes. Schizophrenics who were in contact with psychiatrists, mostly in institutions, over 20 years were 30 times as frequent in the lowest class than in the two upper social classes. The cause of this difference was attributed to pronounced differences in treatment of the upper and lower class schizophrenics. Lower class schizo-

phrenics often received no treatment or only organic treatment; they were referred through legal channels, usually quite late; more important, however, is the fact that their chance to be rehabilitated into their community or family was poor compared with the upper class schizophrenics, who were referred early and through medical channels, treated more intensively and often by better methods, and who had a much better chance for rehabilitation. This work clearly indicates how important socio-economic considerations are in the treatment of schizophrenia at present; probably far more important and, under adverse circumstances, far more limiting than in other illnesses. From a realistic viewpoint, this means that at present only the schizophrenic in the upper socio-economic groups will receive optimal treatment. The less privileged patient and his family will hardly be able to avail themselves of skillful psychotherapy or of an optimal hospital setting. I am optimistic enough to assume that such an unfortunate condition will not last. When a more effective therapy of schizophrenia, based on an etiological understanding is discovered, when an increasing number of psychiatrists are trained in and will devote themselves to the difficult psychological treatment of psychotic patients, and when gradually better endowed services become available, this inequality in treatment will not be more important than in any other illness. To achieve this, however, much research in this field will have to be done and the general public will need to be oriented to insist on better treatment facilities for one of the most devastating diseases.

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My Journey to Israel

Part I

This is the first report of my trip to the Third World Assembly of the Israeli Medical Association. Stopping on my way for four days in Italy, I used one day to visit Orvieto, a small Etruscan town on the road between Rome and Florence. In my opinion this town played an important role in Freud's development as a psychoanalyst. His first visit there was in 1897. This trip led to his first self-analytic publication. One year after this visit he could not recall the name of Luca Signorelli, the painter who had painted the powerful frescoes of "The Last Judgment" in the Cathedral of Orvieto, which are much more frightening than Michelangelo's "Last Judgment" in the Sistine Chapel. He used this forgetting as the starting point for the "Psychopathology of Every Day Life." Signorelli's fiends and devils cause an increase in anxiety which is in sharp contrast to the relief provided by the paintings in the Etruscan tombs, which picture a joyful and festive reception of the souls in Hades.

Freud reported about the impression of the Etruscan graves on him in his "Interpretation of Dreams." This visit occurred at the important moment in his life, when he recognized the fallacy of blaming neurosis exclusively on external traumata and started to develop a more psychological theory of mental disturbances. His own self analysis in connection with his impressions in Orvieto seemed to have been the starting point for this development. On my visit there I was well impressed by Signorelli's murals, which I had seen on many reproductions before and for which I was well prepared. I was, however, surprised at the absence of American tourists who at the same time were overcrowding Rome. The visit to the Etruscan necropolis was less rewarding, as all the contents were removed from there and had to be inspected in the Museo. At the time of Freud's visit there, two skeletons were still lying on the stony benches of the tombs. Many Italian and other European tourists were there but no Americans. During lunch I became acquainted at the Ristorante Moreno with a high Roman police functionary who recognized my driver as a man whom he let go free after his arrest for trying to stow away on an airplane for the U. S. A. My driver, an intelligent high school graduate who spoke a good English, made my trip a more delightful experience.

Twenty years after his first trip to Orvieto, Freud made another self-analytic attempt in which the Pallazzo Bizenci, the hotel where he stayed, played a role. When I inquired about the Pallazzo Bizenci nobody knew anything about it at first. The Coat of Arms of the family Bizenci is still visible on another hotel, the Albergo Reale. I inquired there and the proprietor led me to another house, now used by the Banco di Santo Spirito, and informed me that that was the former Pallazzo Bizenci. The former proprietor did not live in Orvieto any longer and therefore I could not interview him. This disappointment, however, was minor and my visit to Orvieto was an interesting reward for my biographical interest in Freud's travels.

Peripateticus

THE PRESIDENT'S PAGE

FOR at least twenty-five years the high cost of medical care has been of concern to those in government, the recipients of medical care and those who render the service. Of course no one stops to think that in return for this high cost we have added about twenty years to our life span. It would be longer than that if it were not for the slaughter resulting from preventable accidents. We all recall Government's efforts to lower this cost by instituting compulsory health insurance through legislation such as the Murray-Wagner-Dingell bill.

Let me tell you a little yarn. A grandmother brought her daughter's child to my office for medical examination. After she paid me for my services, I showed her a copy of the Murray-Wagner-Dingell bill lying on my desk and told her if Congress passed it she wouldn't need to pay me in the future. She said: "What ya mean Doc?" I told her the Government would pay for my services. She said: "You mean the Government would pay for my child?" I said: "Yes." She said: "Dat ain't fair, cause it takes away from me my right to care for my own." Such philosophy on the part of the American people defeated the Government's attempt to enslave the medical profession and formed the basis for our Nonprofit Hospital and Medical Care Insurance Plans.

In 1938 Governor Cross appointed a Citizens' Committee to look into the needs for such plans. As a result of their deliberations, enabling acts for the establishment of Nonprofit Hospital and Medical Care Plans were passed by the General Assembly of Connecticut in 1939. A short time thereafter our Blue Cross Hospital Plan began operating and the door was open to begin work on a Medical Care Plan.

From the beginning we were determined to explore every possible type of medical care insurance plans, to be sure our plan would meet the needs in Connecticut and be actuarially sound. In your CMS Hand Book you can and should read the history of its development. In between the lines, however, you can see the hours upon hours that have been spent by your committees cooperating with citizens' committees, searching for the facts upon which to build our own Connecticut Medical Care Plan. After all the chips were in, it was clear that the plan should have close Medical Society participation, but should be operated by an independent corporation controlled by a board of directors of highly qualified laymen and physicians. Our CMS organization is such a corporation and opened its doors for operation in April 1949. Will tell you about the phenomenal growth and its beneficial service at a later date.

Oliver L. Stringfield, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

JAMES G. BURCH
Director of Public Relations

JOSEPHINE P. LINDQUIST
Administrative Assistant

160 ST. RONAN STREET, NEW HAVEN

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CALL

SEMI-ANNUAL MEETING OF THE HOUSE OF DELEGATES

The 1955 Semi-Annual Meeting of the House of Delegates will be held at the New Haven Medical Association, 364 Whitney Avenue, New Haven, on Thursday, December 8, commencing at 4:00 o'clock in the afternoon.

The purposes of this meeting are:

1. Action on the budget for 1956 as recommended by the Council.
2. Amendment of the By-laws as recommended by the Council so that Article VIII, Section 1, be amended by the addition of a new paragraph 2 . . . "all past-presidents of the Society shall be ex officio members of the House of Delegates without the privilege of voting." Article VIII, Section 1, is amended so that the present paragraph 2 becomes paragraph 3; paragraph 3 becomes paragraph 4.
3. Action on such other subjects as may be presented in accordance with the By-laws.

Members of the House will be the guests of the Society at a buffet supper following the meeting.

Oliver L. Stringfield, President
Creighton Barker, Executive Secretary

Introduction of Resolutions

By-Laws, Section 4

Par. 1. All resolutions to be introduced before the House of Delegates at an annual, semi-annual or special meeting, except resolutions and recommendations from the Council and resolutions and recommendations that may be contained in committee reports, shall be delivered to the Executive Secretary in time for publication in the official agenda for the meeting at which action is to be taken.

Par. 2. Resolutions and recommendations to be introduced before the House of Delegates at an annual, semi-annual or special meeting by the Council or resolutions and recommendations that may be contained in reports of standing or special committees of the Society shall be published in the official agenda for the meeting at which action is to be taken. The official agenda shall be distributed to

the members of the House of Delegates at the earliest possible date preceding the meeting.

Par. 3. Resolutions and recommendations which do not meet the requirements of Paragraphs 1 and 2, of Section 4 of this article may be accepted for action by a session of the House of Delegates by a majority vote of the delegates present. Such resolutions and recommendations shall be referred at once by the presiding officer to reference committees appointed by him from the membership of the House. These reference committees shall consider the resolutions and recommendations referred to them and shall report, with recommendations, to the House before adjournment of the session.

"New Practice" Assistance Grants Offered

The Sears-Roebuck Foundation, in cooperation with the American Medical Association, has announced a new Plan for Assistance in establishing

medical practice units with loans of up to \$25,000, beginning in 1955. The unsecured, low-cost, 10 year loans will be available to physicians seeking to establish new practices but unable to arrange full local financing. The loans, intended especially for small or medium-size towns, growing suburbs, or rural communities, will be offered to physicians in at least one location in each of five regions covering the United States. Applications will be screened by a medical advisory board selected from AMA Board of Trustees nominations. Investigations and the physician's application will provide the advisory board with information on these questions: Is the proposed location of the unit logical? What will it bring to its community? What is its chance of success? How much initiative has the applicant?

Under the terms of the note, payments of \$12 a month per \$1,000 borrowed are due after three years and must continue until repayment is complete. Accelerated payments may be made. Recipients also must pledge themselves to make a \$240 tax-free contribution to the Sears-Roebuck Foundation for each \$1,000 borrowed. Payments may be made at any time but must begin after the fifth year, at a rate of \$2 per month per \$1,000 for the fifth year; \$3 a month for the sixth and seventh years, and \$4 a month for the last three years. All money returned to the foundation will be used to help establish new practices. Two features are planned to encourage early repayment, so that these additional grants may be made: 1. As long as no repayments are being made on the principal—up to three years—interest at the rate of 6 per cent per year (\$5 a month per \$1,000) is charged. Interest is cancelled as soon as repayments begin. 2. All pledges are to be spread over the last six years of the term, but those not yet due will be cancelled if the grant is repaid before 10 years. Grantees also must be covered by decreasing term life insurance with any insurance company for the amount of their grants excluding pledges.

Further information and applications may be secured from the office of the State Medical Society.

Members Elected at Semi-Annual Meetings

FAIRFIELD COUNTY

M. J. Carl Allinson, Greenwich
William Francis Burke, Newtown
William Harris Burke, Bridgeport
Harry A. Bradley, Jr., South Norwalk
Gunnar Orville Eng, Stamford
Edward J. Gerety, Fairfield
James M. Grant, Bridgeport

James Joseph Griffith, Norwalk
Arthur M. Harrison, Stamford
Paul E. Kaunitz, Westport
Trent Laviano, Danbury
Thomas Dexter Lenci, Fairfield
Alice Ente Madwed, Bridgeport
Paul J. Ostriker, Stamford
Richard Charles Peterson, Stratford
William J. Rogers, Norwalk

LITCHFIELD COUNTY

Frank Edward Smith, Jr., Lakeville
Freeman Brown, Torrington

NEW LONDON COUNTY

John Caruso, Jr., New London
Thomas J. Masterson, Norwich

Meetings Held During October

- October 3—Cancer Coordinating Committee
- October 4—Litchfield County Medical Association
- October 5—Subcommittee on Toxemia
Committee on Industrial Health
Fairfield County Medical Association
- October 6—Committee on Postgraduate Education
- October 7—Blood Bank Liaison Committee
- October 11—State Hospital Advisory Council
- October 13—Public Health Committee
Middlesex County Medical Association
Connecticut Cancer Society
- October 18—Tolland County Medical Association
Blood Bank Committee
- October 19—Council
Committee on Neonatal Mortality
- October 20—Board of Directors—Connecticut
Medical Service
Windham County Medical Association
- October 21—Program Committee for 1956 Annual
Meeting
- October 25—Hartford County Medical Association
- October 26—Committee to Study Maternal Mortal-
ity and Morbidity
Committee on Industrial Health
Fairfield County Association indoctrination meeting for new members
- October 27—New Haven County Medical Association
Eye, Ear, Nose and Throat Section
- October 29—AMA Regional Conference on Nation-
al Legislation
- October 30—AMA Medicolegal Symposium

THE HISTORIAN'S NOTE BOOK

THE SEAL OF THE CONNECTICUT STATE MEDICAL SOCIETY

EDWARD J. WHALEN, M.D., *Hartford*

THE origin of the Seal of the Connecticut State Medical Society as well as the interpretation of the Latin motto of the Society continues to be a challenge to those who have attempted to trace the steps in the history of this interesting emblem of the Society.

In the early years of its history one of the most important duties of the State Medical Society, as provided in the charter, was the examination of candidates who wished to practice medicine. An Examining Committee was appointed at each annual meeting of the Society, consisting of three members of the Society from each County who were, by law, empowered to fill up the blank licenses, previously signed by the President, to which the Seal of the Society was affixed, countersign and deliver them to such candidates in the several counties, as on examination were deemed worthy to receive them.

Great value was attached by these newly licensed doctors to the presence of the Seal on the certificate issued in those years when a committee of the State Medical Society granted the license to such as were found qualified to practice Physic and Surgery. The certificate issued by the Society to successful candidates was the only evidence to show that the doctor had passed such an examination. Many of the doctors complained of the small size of the certificate and at times the absence of the Seal, which was the only outward sign that served to distinguish them from the unlicensed and irregular practitioner.

One must know the state of medicine in the world at the end of the 18th century to understand the thoughts of doctors in Connecticut during this period. At the end of the 18th century two subjects filled the minds of physicians, the first being what methods to use to increase their knowledge of disease. The second and the one most discussed was the need for protecting the community from the impositions of "quacks, charlatans and pretenders." The 18th century was the age of successful

quacks and in the words of Thoreau, "Quackery if not universal was at least universally successful."

From Norwich in 1763 came a petition from eleven physicians in the Norwich area addressed to the General Assembly of the Colony of Connecticut, humbly pleading that the doctors be allowed to organize as a group so that the community might be protected from Quacks and Empirical Pretenders. The petition was for a charter for a medical society. The petition was denied.

In Litchfield County the doctors met at Sharon in 1780 for what was described in the announcement as, "The First Medical Society in the Thirteen United States of America Since Their Independence." During the Oration given at this meeting the orator promised that, "No more shall you hear the illiterate jargon of deluding medicators nor feel the unhappy effects of enterprising imposters."

The medical practitioners of the County of New Haven met in 1784 for the purpose of resolving themselves into a Society. They listed five purposes in establishing a medical society. The fifth purpose was, "For uniting with the several Medical Societies within the State in a joint application to the Legislature, praying them to adopt such measures for the future regulation of our Salutary Art as shall effectually support and countenance Merit and discountenance Ignorance and Presumption." This New Haven group met under the chairmanship of Dr. Leverett Hubbard and the five purposes of the proposed society may well have been written by him.

The projected organization of doctors aroused a heated discussion in New Haven and not all the citizens looked with favor on what they feared was a medical monopoly. Letters were written to the papers and one such letter published in the *Connecticut Journal* in January 1784 read in part as follows: "This in time would answer all the purposes of reducing the Medical Profession to a Regular System and prevent the World from the

horrid Impositions of Quacks, Medicasters and vain Pretenders with which it is now infested." The letter was signed, "Medicus," and since the language is the same as that used in the resolutions of the proposed New Haven County Society, whose author was probably Leverett Hubbard, it may well be that Dr. Hubbard was the "Medicus" of the letter to the *Connecticut Journal* again expressing the thought that the doctors, through organization, could "discountenance Ignorance and Presumption."

Eight years later, in 1792, the Connecticut Medical Society was organized and Leverett Hubbard was elected the first President. At the next meeting, in 1793, the Society voted, "That the thanks of the Society be given to their President for the Society Seal which he had given to the Society." It is probable that Leverett Hubbard directed the design and inscription of the Seal since it was his gift to the new Society.

It is clearly evident that Connecticut doctors were eager to organize during the last half of the 18th century. Many New England communities harbored one or more so called doctors, all without training or knowledge of disease. Sometimes such training as they claimed was limited to having acted as coachman or butler in the household of a busy doctor. The regular practitioners must have been constantly brought to witness the tragic results that followed the ministrations of the ignorant or deceitful meddler in the care of the sick. Such were the conditions that the regular and trained physician sought to correct. It was this evil situation that was in the minds of those who planned a state medical society.

It was in the period about 1900 that the reorganization of the American Medical Association was being carried out. The revision of the by-laws of the American Medical Association included plans for the integration of the county and state medical societies as constituents of the national body. As part of this plan the various state medical societies were requested to identify their status by including the word "State" in the title of their society.

The report of the Secretary of the State Society, Dr. Walter Steiner, dated May 22, 1907 includes the statement: "I was instructed last year to add the word 'State' to the Seal but I have been unable to get a description of the original Seal and consequently have felt unwilling on my own responsibility to go ahead without further instructions."

Again Dr. Steiner, as Secretary, reported to the

Society under date of May 26, 1909, "During the past year Dr. Nathaniel E. Wordin of Bridgeport, one of our former Presidents and for sixteen years our Secretary, sent me an early license to practice medicine in this State, which he had in his keeping. It was issued by the Connecticut Medical Society in 1796 and contains an impression of the Seal of the Society, being the earliest copy of the Seal with which I am acquainted. Accordingly I have had it photographed and enlarged. The enlargement has been used as a pattern, to follow as faithfully as possible, for our new seal, in which the word 'State' has been inserted. To do this, it has been necessary to abbreviate our title on the Seal. Through the cooperation of Prof. J. W. D. Ingersoll of the Latin Department of Yale University this has been done, and the new Seal will now be used on all the licenses to practice medicine, which we issue."



Seal on certificate issued to Thomas Miner, Brooklyn, Connecticut, April 25, 1796. Signed by Eneas Munson, president

Dr. Creighton Barker, in planning the 1948 Annual Meeting of the State Society, wrote this foreword to the program: "The drawing on the cover is from the Seal of the Society, authorized on October ninth, Seventeen Hundred and Ninety Two, and accepted October sixteen, Seventeen Hundred and Ninety Three. The designer of the Seal is not known. Cui Meruit in the wreath signifies laurels or award to him who merits and the motto Fide et Diffide beneath proclaims faithfulness and modesty. The symbolism of the separated hands

approaching as if to clasp is not understood accurately and has been discussed often. A plausible explanation is the hand of fellowship being extended to another physician on becoming a member of the Society."

The significance of the symbols on the Seal holds our interest since the interpretation permits a variety of readings. One approach to the understanding of the motto and figures is to send our thoughts to Connecticut in the late 18th century. Doctors at that time were convinced that they should form a strong association for the purpose of sharing their knowledge of medicine and of equal importance was the need to eliminate the charlatan from the community. These thoughts are expressed in the Seal. Cui Meruit surrounded by the wreath is a pattern frequently found on seals and is usually read, "Let he who merits it wear the palm of victory." The extended hands presents a problem since the Seal shows two left hands, extended in greeting. The Apostle Paul in an Epistle to the Galatians wrote, "And so, recognizing the grace God has given me, they joined hands in fellowship with Barnabas and myself." The hand of fellowship extended to one who is welcomed to the association of trained physicians is readily understood. The reason for two left hands is without explanation. It may be that the engraver of the Seal nodded at his task. At the base of the Seal the motto, Fide et Diffide, admits of many readings. If we try to think along with Leverett Hubbard who probably designed the Seal, it could be translated, "With Confidence and Humility." Dr. Hubbard had written repeatedly that it was the hope of the doctors that measures could be adopted for the future regulation of Medicine, "As shall effectually support and countenance Merit and discountenance Ignorance and Presumption." When he directed the design of the Seal the same hope was expressed, that Merit should be endorsed and that the evils of Ignorance and Presumption would no longer prevail but would be replaced by Confidence and Humility.

In the East, the age old custom of using a seal as a stamp of authentication parallels the western habit of inscribing a signature. The legend is an expression of hope or a statement of principles. To the members of the Connecticut State Medical Society, the Seal carries this message. Let he who has won the palm of victory be welcomed with the hand of fellowship. Let him as a physician observe Confidence and Humility. Confidence in the belief that he is practicing Medicine in accordance with the

Truth as he knows it. Humble in the conviction that he is the inheritor of the world's accumulated knowledge.

Confidence and Humility are prime virtues when found in a doctor.

CONNECTICUT STATE DEPARTMENT OF HEALTH

Newly Licensed Physicians: Month of September, 1955

DATE OF LICENSURE

- 1955
- September 1 Willard F. Greenwald, M.D., 816 Orange Street, New Haven, Conn.
- 2 William F. Westlin, Jr., M.D., 22 Greenough Place, Newport, R. I.
- 6 E. Gordon MacKenzie, M.D., Millbrook, N. Y.
- 7 Allan A. Brandt, M.D., 7-9 Lafayette Street, Milford, Conn.
- 8 Andrew G. Reitwiesner, M.D., 45 Grandview Avenue, Mt. Vernon, N. Y.
- 9 Michael Hume, M.D., 333 Cedar Street, New Haven, Conn.
- 9 Saul W. Brusilow, M.D., 70 Central Avenue, Apt. 51, New Haven, Conn.
- 12 John L. Brockmann, M.D., 512-B Paulding Avenue, Warrington, Florida
- 15 Joseph C. Czarsty, M.D., 314 Main Street, Oakville, Conn.
- 16 George M. Stern, M.D., 285 Vine Street, Hartford 12, Conn.
- 19 Michael J. Badeen, M.D., Millerton, N. Y.
- 20 Gilbert J. Rose, M.D., 7 Glendening Street, Norwalk, Conn.
- 21 Elwood F. Ireland, Jr., M.D., 857 Bronson Road, Fairfield, Conn.
- 23 Irving Schneider, M.D., 777 Savin Avenue, West Haven, Conn.
- 26 Lewis M. Bloomingdale, M.D., Wilmot Road, Scarsdale, N. Y.
- 26 Virginia Sutenfield, M.D., Psychiatric Clinic for Children, Inc., Stamford Hospital, Stamford, Conn.
- 26 Francis W. Westneat, M.D., 2331 Whitney Avenue, Hamden, Conn.
- 26 C. Robert Rubenstein, M.D., 333 Cedar Street, New Haven 11, Conn.
- 26 Douglas J. Roberts, Jr., M.D., R. F. D. No. 1, Rockville, Conn.
- 27 Leonard K. Smith, M.D., 209 Laurel Street, Longmeadow, Mass.
- 29 Maurice Lunger, M.D., Hartford Hospital, Hartford 15, Conn.
- 29 William F. Kraft, M.D., 300 Warwick Road, Somerdale, N. J.

Special Article

THE BASIS FOR SERVICE BENEFITS

The Full Payment Concept of Blue Shield

WILLIAM H. HORTON, M.D., *Windsor*

The Author. *Executive Director, Connecticut Medical Service*

THE words Service Benefits have become the most controversial words in the practice of medicine. The concept which they represent has been the subject of more argument than any other aspect of the economic side of medical practice. With the rapidly changing application of voluntary health insurance there is every indication that there will be more, rather than less, discussion of Service Benefits in the future.

This seems a suitable time to begin the use of the term Full Payment in place of our Blue Shield term Service Benefits. This change was the consensus of the discussions of Service Benefits in the Blue Shield Commission and in the Annual Conference of Plans in April. Full Payment is what we are talking about when we say Service Benefits and it will be clearer to all of our members if we use the simple term Full Payment instead of the ambiguous Service Benefits which has a different meaning for each person who hears it.

Why should Service Benefits—Full Payment have aroused so much feeling among the profession?

Full Payment is controversial in medicine because when we talk about Service Benefits we are talking about money—physician's money—payment for physicians' professional services. Then too, we are also talking about fixed fees for services. If there are any two subjects which will arouse the physician's interest they are: payment for his services and the question of fixed fees. It, therefore, is not remarkable that they have become the subject of so much controversy since Full Payment is intimately concerned with both of these significant matters.

Most of the discussions of Full Payment have been highly emotional and in many cases based upon

an isolated unfortunate personal experience. Some physicians have not even waited for the experience but with active imaginations have conjured up all sorts of tragedies which would befall the practice of medicine if Full Payment, even on the limited basis currently in use in Blue Shield, should become an accepted principle of the practice of medicine. It is paradoxical that seldom have the opponents of Full Payment considered the extent of the disaster which will befall medical practice if the failure to provide Full Payment to the groups which deserve it, influences Congress to have the government decree by legislation what the physician was unwilling to provide voluntarily.

It is unlikely that anything which may be said on behalf of the Full Payment or Service Benefit principle will ever convince a considerable number of participating physicians. Neither does it seem likely that Blue Shield plans will ever be able to satisfactorily answer every physician's individual complaints regarding the inequities which will occasionally result from the practical application of the Full Payment principle to his practice. Nevertheless, it seems worthwhile for those of us who regard the Full Payment principle as essential to the continued independence of medical practice to continue to try and persuade our colleagues of the soundness of our viewpoint.

It seems useful to review for a few moments the over-all concept of Full Payment as it is applied to medical practice. It may be that by doing so we can bring to your attention some of the more significant considerations of the problem which frequently are lost sight of by a physician occupied with the concerns of a busy practice.

The views expressed are my own and not necessarily those of Connecticut Medical Service. Since there was some misunderstanding of my feeling as to the extent to which the Full Payment principle

should be applied, in my previous comments on the subject, I should like to be very definite regarding the subject. I do not believe that the Full Payment principle should be applied to all levels of income. Such a situation would inevitably produce mediocrity in medical practice by removing any incentive for a physician to excel in a particular field of medicine and be properly remunerated for his skill. I do believe, however, that Full Payment must be made available to all the lower levels of income where anticipated medical care expenditures cannot be met by the individual without sacrificing other necessities for a desirable standard of living.

I do not wish to be repetitious but it will be necessary to restate some of the principles in order to present my philosophy of the Full Payment concept.

There are only three statements that need to be understood and accepted by any practicing physician in order for him to be willing to give his unqualified support to a Full Payment program. The first is that Full Payment is the only practical manner in which the traditions of the medical profession can be applied to the practical considerations of the business of running an insuring company. Second, Full Payment is primarily for the welfare of the patient whose interest medicine has always been proud to protect, and lastly, Full Payment is the only means by which medicine in the long picture can be maintained as a voluntary profession.

I think you will all agree that if these statements are factual, every practicing physician would be as morally and ethically obliged to support the Full Payment concept with his best efforts, as he does his county medical association; or he would wish to support it simply as a matter of prime self interest. Let us see how well we can prove to you the truth of these statements. The first statement, "Full Payment is the only practical manner in which the traditions of the medical profession can be applied to the practical considerations of the business of running an insuring company." The traditions of the medical profession have always insisted that the welfare of the patient be the first consideration of the practicing physician. When these principles were initiated there was no such thing as medical care insurance but these ethical principles have not been significantly modified, despite the tremendous growth of voluntary prepaid medical care. These principles are accepted as a basic obligation by

every ethical physician in medical practice. I am sure that most physicians will agree that the circumstance that money is made available through an insurance corporation for the payment of physician's services when they are required, should not make the practicing physician any less dedicated to the fulfillment of his ethical responsibilities in the traditions of medicine. His prime interest is in the welfare of his patient.

If the low-income patient must have the professional service regardless of whether or not he has funds, which is medicine's pledge to him, why should not adequate funds provided by an insuring company be acceptable as full reimbursement by the physician, particularly when the physician himself arranges the fee schedule as he does in Blue Shield. Surely half a loaf is better than none and the Service Benefits-Full Payments being made today by the better Blue Shield plans are far from being "half a loaf." This is a sound, logical, direct and practical application of the principle of medical ethics to the insurance of medical care for the lower income groups.

All insuring companies provide certain dollar amounts which will be paid should the risk occur for which liability has been assumed. Such payments are called indemnities since like all forms of commercial insurance they indemnify, that is to say, 'compensate' or 'make restitution for,' the loss resulting from the occurrence of the risk. As far as I know there has been no over-all objection to indemnity voluntary health insurance by the medical profession although I believe, on a specific claim basis (particularly in the compensation and third party negligence fields), there is frequently a wide difference of opinion between the insurer and physician as to the value of the latter's professional services.

To return to the over-all view, if each practicing physician developed a schedule of fees which he would accept as Full Payment for the services which he renders his patient and if the insurance carrier could sell such a contract to his patients, the physician presumably would then be willing to accept the indemnity fee as Full Payment for his services. The transaction would have no such inflammatory title as Service Benefits. It would be indemnity insurance and the physician would be pleased with the situation. Let us examine for a moment the sources of his satisfaction. The professional service which he renders will be covered

by insurance. He, therefore, may anticipate 100 per cent collections. Next, he is going to receive for his professional services the amount of money which he thinks is his due since he himself set the fees in the schedule. Lastly, he knows his patient will be pleased because the patient will not have to spend any of his own funds, obviously every patient's idea of medical Utopia.

Let us compare this optimal situation with the practical functions of an existing Blue Shield Service Benefit or Full Payment program. They differ in only one respect and again the consideration is money. In the first instance the physician set up his own fee schedule himself, while under Blue Shield plans it is arranged and accepted by himself and a large group of his fellow practicing physicians rather than by himself alone. It seems very definite that the only obstacle the nonparticipating physician finds to supporting a Full Payment program is that in order to do so he must relinquish his right to construct his own individual fee schedule for every professional service he renders. The nonparticipating physician is not willing to relinquish this right even to his fellow physicians and work with them to construct the schedule, although he has just as much influence as each of them in the determination of dollar amounts of the Blue Shield Full Payment schedule. In Connecticut there are some 3,000 practicing physicians. Over 2,500 physicians participate in CMS and provide Full Payment services in accordance with the provisions of the contracts. We can hardly solve the problem for our nonparticipating physicians by having one schedule for 2,547 participating physicians and 500 additional individual fee schedules for each of the nonparticipating physicians.

How does the low income patient feel about not having Service Benefit-Full Payment from the nonparticipating physician? The low income patient is just as interested as is his physician in fully insuring himself against loss should certain risks occur. When you and I have an automobile accident we would like the insurance company to pay in full for the damages. The low income patient feels the same way about his medical care. We do not like deductible collision insurance. We have to; but then the repair of cars is a trade and does not require the same considerations as a profession such as medicine.

The low income patient feels he should be able to buy complete protection against the hazards of illness. It seems reasonable that he should be able to do

so. Why is he unable to? Because, except for those who are participating Physicians in the medically sponsored Blue Shield plans, physicians are unwilling to tell anyone the dollar amount they will accept as full fees. The patient, therefore, buys coverage with the highest medical fee payments he can afford in the hope that the indemnity he receives will be adequate to meet the physician's bill in full. More often than not it does not do so.

The patient then finds it hard to understand what has happened to all the solicitude that he understood the medical profession has always felt for his welfare. If the medical profession is to adhere to its ethical position that service to the patient is the first motivation for practice, then ultimately it must accept a reasonable fee as Full Payment for the services rendered to low income patients. The dollar amount of any fee is not the significant factor in the operation of an insuring company. The stability of the dollar amount and its acceptance by all physicians are the pertinent criteria.

Let us consider the second statement. "Full Payment is primarily for the welfare of the patient whose interests medicine has always been proud to protect." Many physicians who are opposed to Full Payment base their arguments on the effects which they feel it has on their practice. Full Payment is not intended primarily to benefit the financial aspects of the physician's practice although it has proved to do so in many cases. It is the welfare of the patient which is the foremost consideration when Blue Shield devises contracts which provide Full Payment for patients with low incomes.

The physician may conceivably, but rarely, be able to make a sound case for the adverse effects which Full Payment to lower income groups would have on the financial return of his practice. By doing so, however, he is arguing against the ethics of his profession which require that the welfare of his patient, not the financial return of his practice, be his first consideration. I have yet to hear a sound argument against Full Payment in terms of the welfare of the low income patient.

The last statement, "Full Payment is the only means by which medicine in the long picture will be maintained as a voluntary profession" does not require extensive documentation to demonstrate its truth.

The variable fees of the past and the present were and are based on the ability of the patient to pay. In a day when a large segment of the popula-

tion was unable to pay medical costs, variable fees were a reasonable means of effecting an average payment for all patients. There is little question but that the vast majority of our population can now pay the costs of Blue Shield membership charges if a contract is available to them. In view of this circumstance, justification of variable fees will and must become more and more difficult.

There is an easy tendency to assume that any fee which is fixed is necessarily incorrect. This is far from the truth. One of the major reasons why the cost of physicians' services (although increased) have not kept pace with the rising costs of living is because most physicians have adhered for many years to their own particular pattern of fees. These fees, of course, are fixed but they are fixed by the physician himself and, therefore, we may presume that he feels they are correct. Once again we return to the view that the correctness of a fixed fee depends upon who is doing the fixing!

Medical fees in the future for the vast majority of our population must be fixed. It is only on that basis that it will be possible for insurers to provide coverage and for patients to meet medical costs. It is idle to advise a patient that he should budget from his income to meet the costs of his medical care unless you are willing to tell him what he may expect those costs to be.

Under Full Payment-Blue Shield Service Benefit Plans, practicing physicians are the ones who fix the fees for themselves. This is as it should and must be. The practicing physician has nothing to say about the fees provided in commercial insurance contracts. If we eventually come to a governmentally controlled medical care program, medical fees (in keeping with familiar bureaucratic policy) will probably be arrived at by the one person who can be found in government who knows least about the practice of medicine, certainly not by the practicing physicians who will provide the professional services.

I have tried to summarize in four axioms the present situation as far as the practicing physician is concerned.

1. If, in the future, the physician expects to be paid, the insurance coverage must do it.
2. If insurance is to do it, medical fees must be stabilized.
3. If medical fees are to be stabilized, practicing physicians ought to do it.

4. If practicing physicians are going to do it, each physician must surrender some of his individuality on behalf of the profession as a whole.

I believe these statements represent a sound simplification of our complex problem, a bedrock foundation for future medical practice that cannot be circumvented, no matter how much we might wish to do so. There is only one remaining consideration in this discussion of Full Payment. If Full Payment-Service Benefits is not the answer to the problem of meeting the medical care costs for low income groups, what is?

Certainly the answer does not lie with indemnity insurance.

Medical costs must not be "all the traffic can bear," they must be reasonable and proper for the services rendered. The public already seems to be aware that in some instances indemnity insurance may represent a liability rather than an asset when their physician comes to make out his bill.

Blue Shield Service Benefits-Full Payment plans represent the most forward step which the medical profession has yet taken to make it possible for patients to have the best medical care at a price they can afford to pay. No indemnity insurance plan can argue that its benefits are equivalent or better than a Blue Shield-Full Payment plan. Blue Shield Service Benefits-Full Payment contracts possess the quality (if I may paraphrase the slogan of which a leading pharmaceutical firm has long been proud) "the priceless ingredient, the honor and integrity of the physician." Full Payment contracts of Blue Shield plans guarantee Full Payment coverage; this no indemnity plan can do.

I believe that we have satisfactorily demonstrated the truth of the three statements originally made in this paper. While our discussion has been necessarily limited and to some extent superficial, I believe that a more detailed review of the implications of the four axioms will further support their accuracy.

The American public, the patients, and not the medical profession will ultimately decide whether the practice of medicine continues to be voluntary or becomes subsidized and controlled. Unless it is possible for a majority of our people to insure themselves fully against medical care costs for significant medical treatment, the final decision of the public can be easily anticipated, and the medical profession will not like it.

FROM OUR EXCHANGES

Peter's "Some Remarks on Diabetic Acidosis" is a more than commonly informative discussion of the causes and treatment of diabetic acidosis (*Yale Jour. Biol. & Med.*, 27:3, pp. 152-167). The author calls attention to the fact that mortality can be reduced if the latest knowledge and technical facilities are utilized. They should not, however, be reduced to a stereotyped routine. Details of application must be individualized.

In no other disorder can a more profound state of dehydration be produced in so short a time. Circulatory collapse is an ever present danger. The patient with diabetic acidosis should be grouped at once and blood should be ready for immediate use if required. The administration of fluids should be continued simultaneously. The object of the transfusion is not only to expand the volume of the circulating blood but also to improve the state of the circulation so that it will pick up fluids from the tissues. Attention is called to the necessity of providing carbohydrates more rapidly when the blood sugar concentration diminishes. The rate of administration of insulin should be retarded at the same time. A hypoglycemia reaction during recovery is hazardous.

Potassium and phosphate excretion increases during the early development of acidosis, though their concentrations in the serum does not fall. As the condition advances and renal function suffers, the excretion of potassium and phosphate diminishes and their concentration in the serum rises. As hydration is restored, their concentrations are reduced by the processes of dilution and accelerated excretion. The hypopotassemia may give rise to serious symptoms of which the chief are extreme weakness, collapse and heart failure. Although frequent measurements of blood sugar are the best index of success of treatment they should be interspersed with measurements of bicarbonate and chloride, both sodium and potassium. Sole reliance for evaluation of potassium should not be placed on the electrocardiogram because this is not specific and because cardiac disorders should be anticipated and prevented. If the serum potassium falls below 3.5 mEq. per liter, injection of potassium is indicated; 90 mEq. is ordinarily a satisfactory dose, though it

may be necessary to repeat the dose. The potassium should be given highly diluted in glucose or saline at a slow rate, with the blood flowing freely through the vein, since, if the potassium reaches a high concentration in the vein, it causes excruciating pain. Since phosphate is also greatly depleted, the use of potassium phosphate appeals to the chemical sense, although the deficiency of phosphate appears to have no deleterious effect. As soon as the patient can take a mixed diet, danger of hypokalemia is eliminated.

* * * *

In a preceding article on the "Management of Diabetes Mellitus" (*Yale Jour. Biol. & Med.*, 27:2, pp. 75-89) Peters calls attention to the fact that diabetes is a disorder of metabolism; and that it must be treated with consideration of the physiology and chemistry of the metabolic processes and the effect of other vital activities upon these processes. The management of diabetes requires a radical reorganization of the whole conduct of life, usually for the duration of life and must, therefore, be planned and conducted with the careful and sympathetic attention to the patient's habits, predilections, and activities. Interest must not be centered on the metabolic condition to the neglect of complications and associated disorders.

* * * *

Conklin, like others, has practically abandoned the use of artificial pneumothorax, phrenemphraxis and primary thoracoplasty in the treatment of pulmonary tuberculosis ("Surgical Trends in Pulmonary Tuberculosis," *Dis. of Chest*, XXVII:2, pp. 147-164). Pulmonary resection is preferred to collapse therapy because it is a more definitive and permanent means of control and is more conserving of respiratory function. The complications of artificial pneumothorax and extrapleural plombage are avoided. Sputum conversion is usually immediate. There is commonly a shorter period of morbidity; and rehabilitation is earlier. The author believes that pulmonary resection will materially reduce the number of hospital readmissions due to reactivation and spread of the disease. Public health benefits if infectiousness is readily and promptly controlled.

The author admits that resection therapy may be used too widely. The new antimicrobial medication now available, and those that will doubtlessly be added, can obviate much of surgery which is now performed. He adds that we must continually re-evaluate our position. Conklin suspects that in another 10 years we may look back on this heyday of resection as we do now on that of pneumothorax therapy.

“For while time is said to heal all wounds it must also wound all those who would continue to heal by the convictions of yesterday.”

It is suggested by Donnelly and Kearns that a number of maternal complications may occur as the result of the escape of intrauterine products into the maternal blood stream. ("Thromoplastic Complications of Pregnancy." *N. Car. Med. Jour.*, 16:2, pp. 39-44.) A review of the records of the Committee on Maternal Welfare reveals that failure of coagulation due to hypofibrinogenemia has apparently not been common. The diagnosis of hypofibrinogenemia depends upon the presence of certain antecedent conditions: abnormal bleeding without evidence of clot formation, and disturbed clotting mechanism as demonstrated by the Lee-White clot observation test. Treatment consists of prevention or control of toxemia, careful selection of patients for pituitary extract induction, and whole blood transfusions when necessary. Purified fibrinogen factor may be of value in controlling the active bleeding while whole blood replacement is being made. Purified fibrinogen may prevent the onset of serious bleeding in the event of long standing intrauterine fetal death and amniotic fluid emboli.

Imber and Clymer report a "Case of Obstruction of the Renal Artery Producing Malignant Hypertension" (*New Eng. Med. Jour.*, 252:8, pp. 301-304). The obstruction was due to a fibrous band constricting the renal artery. In spite of the bilaterally diminished renal function, removal of the offending kidney, which pathological examination showed to be normal, effected a "cure" of the hypertensive state by the most rigid criteria. The authors feel that the value of abdominal aortography in identifying the vascular defect is again demonstrated.

Nelson reported on "Five Hundred Cases of Erysipeloid" treated in his practice. More than half

the cases occurred among packing house employees (*Rocky Mt. Med Jour.*, 52:1, pp. 40-42). Surgery was necessary in only a few cases. The diagnosis was obvious, showing sharp limitation of the process to one location, usually the hand, clinical appearance of the erythematous edematous lesion with tenderness of the parts, and the characteristic violaceous color with clearing in the center while slowly spreading peripherally. Penicillin was the treatment of choice.

Rupture of the aortic valve may occur as a result of trauma, strain or bacterial infection. Leonard *et al.* report on a case with a therapeutic approach (*New Eng. Jour. Med.*, 252:6, 208-212). The case reported suffered a traumatic rupture of the aortic valve, and probably a rupture of the interventricular septum (as shown in two cardiac catheterizations). Because of the poor prognosis in sudden free aortic insufficiency, both traumatic and nontraumatic, an artificial valve was inserted in the descending aorta. Fourteen months after the operation the patient was symptom free and working full time as truck driver.

THE DOCTOR'S OFFICE

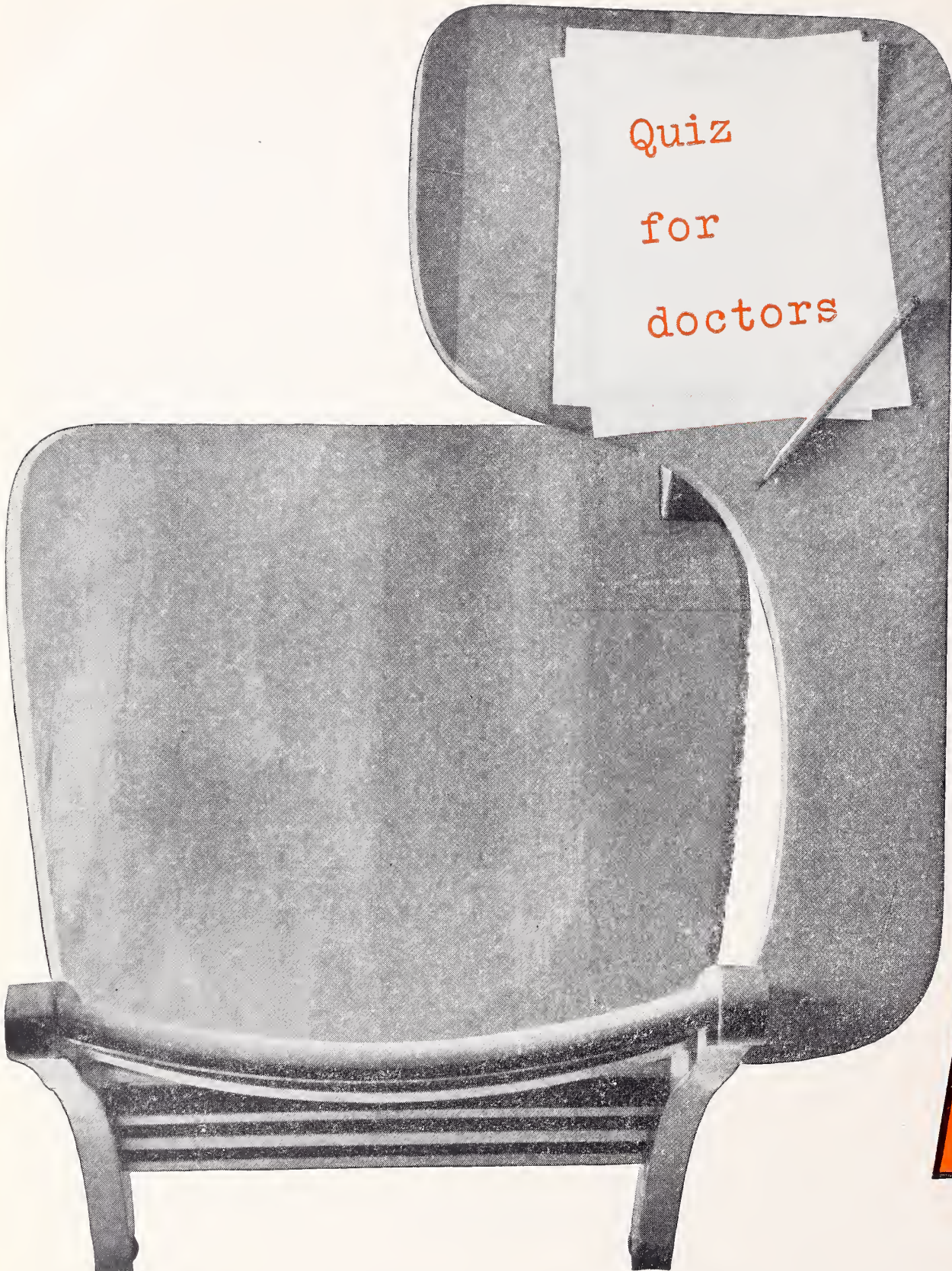
William D. Cochran, M.D. announces the opening of an office for the practice of pediatrics, in association with James W. Sayre, M.D., at 280 Montauk Avenue, New London.

Arthur M. Harrison, M.D. announces the opening of an office for the practice of internal medicine at 112 Hoyt Street, Stamford.

Robert J. Manjoney, M.D. announces the opening of an office for the practice of general medicine at 2464 East Main Street, Bridgeport.

William M. Stahl, Jr., M.D. announces his return to practice with the opening of his office at 30 West Street, Danbury.

PLAN TO ATTEND THE AMA
CLINICAL SESSION IN BOSTON
NOVEMBER 29 - DECEMBER 2, 1955



Quiz
for
doctors

AC

(you probably know every answer!)

Q. Which is today's most widely prescribed broad-spectrum antibiotic?

A. ACHROMYCIN — it's first by many thousands of prescriptions.

Q. What are some of the advantages of ACHROMYCIN?

A. Wide spectrum of effectiveness.
Rapid diffusion and penetration.
Negligible side effects.

Q. Exactly how broad is the spectrum of ACHROMYCIN?

A. It has proved effective against a wide variety of infections, caused by Gram-positive and Gram-negative bacteria, rickettsia, and certain viruses and protozoa.

Q. In what way are ACHROMYCIN Capsules advantageous?

A. For rapid and complete absorption they are dry-filled, sealed capsules (a Lederle exclusive!) No oils, no paste...tamperproof.

Q. Who makes ACHROMYCIN?

A. It is produced — every gram — under rigid quality control in Lederle's own laboratories and is available only under the Lederle label.

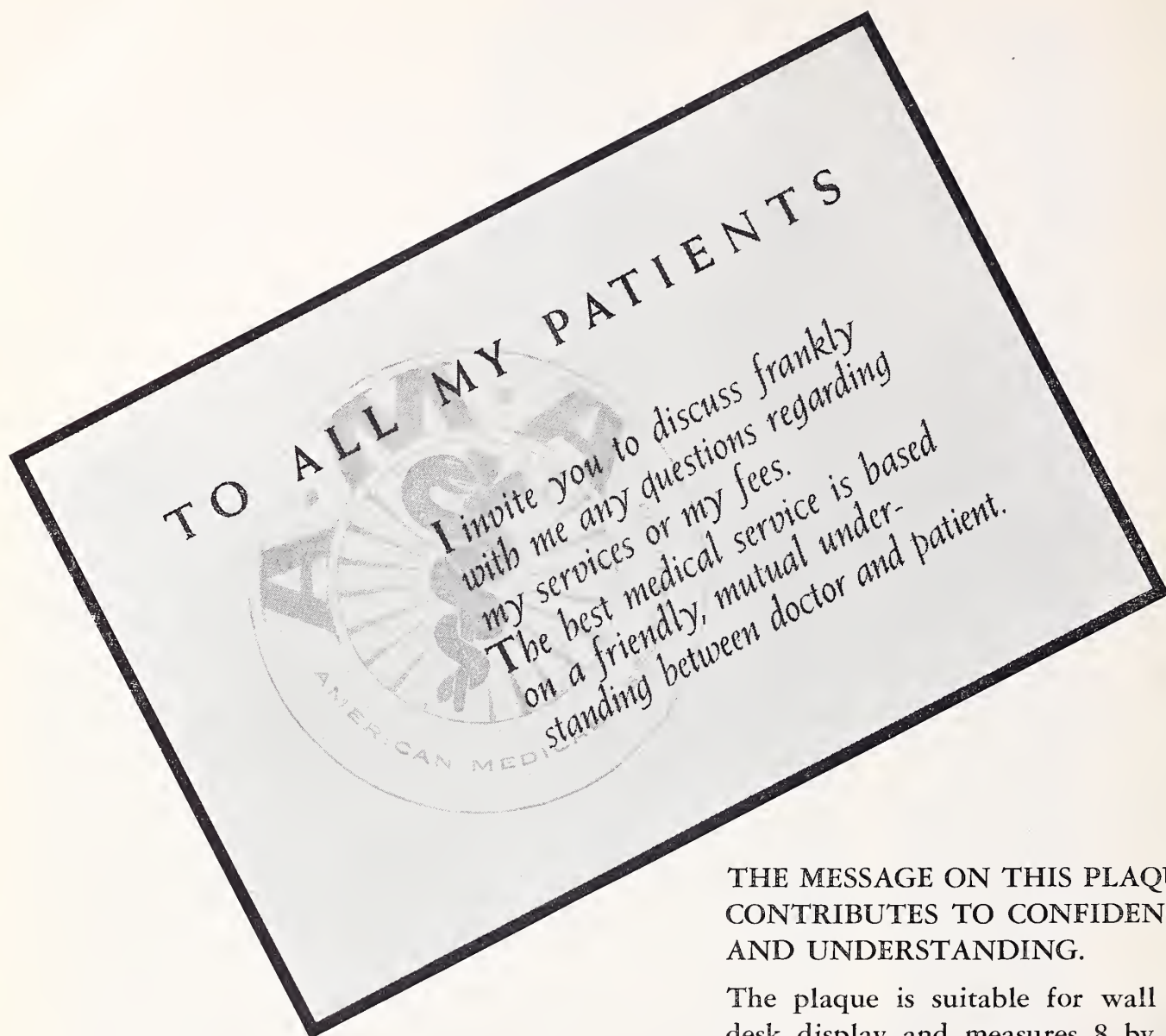
ACHROMYCIN*

Hydrochloride
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LEDERLE LABORATORIES DIVISION AMERICAN *Cyanamid* COMPANY PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.



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Medical Office Planning Guide Made Available to Physicians

A planning guide for establishing medical practice units was recently announced by the Sears Roebuck Foundation.

The eighty-five page guide was edited by the American Medical Association and contains many illustrations and floor plans. The plans comprise suggested arrangements for consultation and treatment rooms for physicians in general practice, pediatricians, internists, and surgeons. The guide measures 11 x 14 inches and also includes information concerning the selection of a location for a medical office, zoning factors, comparative cost of properties, new building construction and remodeling. Lists of equipment, including cost, are also contained in the guide.

Copies of the guide are available to physicians on a loan basis through the offices of the State Medical Society.

New Connecticut TV Series

A new series of thirteen weekly health education telecasts was inaugurated October 20 by the Connecticut TV Committee for Health Education.

The first program in the series, "Preparing Your Child For the Hospital," was sponsored by the Connecticut Hospital Association, one of the fifteen state-wide organizations represented on the committee. Titled, "Accent on Living," the series is being presented from the studios of WKNB-TV, New Britain (Channel 30).

Other programs in the series have been scheduled as follows: October 27—Getting a Chest X-ray; November 3—What About Diabetes; November 10—Your Child and Arthritis; November 17—Watch Your Waist Line; December 1—Doing Something About Colds; December 8—Planning a Safe Christmas; December 15—Tackling Speech Problems; December 22—Alcoholism, a Disease; December

29—Check Your Medicine Cabinet; January 5—Working With Your Heart; January 12—Cancer in Children.

Connecticut First Aid Chart Chosen by Colorado State Medical Society

The Colorado State Medical Society has chosen the First Aid Chart published by the Society's Committee on Public Relations and the Woman's Auxiliary for distribution in connection with a television health education project.

The project will comprise a continuing series of weekly programs and the Chart will be furnished to members of the audience who mail postcard requests after viewing the Chart at the conclusion of each program.

The Chart is designed for attachment inside the door of a medicine cabinet and is also suitable for wall hanging. Previously, requests have been received from other States for use of the Chart in connection with health fairs and organization meetings. Many thousands of copies of the Chart have been distributed at Connecticut fairs by members of the Woman's Auxiliary.

Fairfield County Association Sponsors Second Health Exhibit at Danbury Fair

The Fairfield County Medical Association sponsored its second annual participation in Danbury Fair last month with the exhibit "You Can Reduce" supplied by the American Medical Association. According to Dr. D. Olan Meeker, Riverside, chairman of the Association's Public Relations Committee, the project was highly successful. A weight scale proved to be a popular feature of the exhibit and more than 20,000 educational leaflets concerning reducing diets were distributed to fair-goers.

Through the nine day run of the Fair, October 1-9, one or more physicians were on duty at all times, assisted by members of the Woman's Auxiliary to

the Association. In addition, two hospital dieticians also served as volunteers. The fair attracted more than 140,000 visitors.

Physicians manning the exhibit included: Frederick W. Finn, Tiber deCholnoky, James I. Porter, Greenwich; Robert C. Joy, Louis Rogol, Benjamin Epstein, Roger P. Castro, John D. Booth, William M. Stahl, Jr., and Henry N. Blansfield, Danbury; Halsey G. Bullen, Stamford; E. Tremain Bradley, South Norwalk; Leonard A. Howard, Cos Cob; M. David Deren and George K. Pratt, Bridgeport; and D. Olan Meeker, Riverside.

Members of the Auxiliary were recruited by Mrs. William Sinton, chairman of the Rural Health Committee, Danbury. Dieticians present were Miss Olive Bacon, Danbury Hospital, and Miss Betty Ann Johnson, Greenwich Hospital.

Emergency Call Exhibit Displayed by Middlesex County Association

The Middlesex County Medical Association recently sponsored an exhibit on emergency call plans in a display window of the Middletown Savings Bank.

The exhibit, furnished by the State Medical Society, attracted the attention of many Main Street pedestrians during the week of October 7-14. Leaflets concerning organization and operation of the two emergency plans in Middlesex County and in fourteen other population centers were distributed during the week to patrons of the bank.

The exhibit is self-contained and is illuminated for night use in display windows or at interior display points which are insufficiently lighted. The exhibit may be used for table display at health fairs and other activities. It measures three feet in height and five feet in width when opened for display. It is available for use by county and local medical associations without charge except for shipping costs.

Hartford County Medical Association Starts Campaign for AMEF

The Hartford County Medical Association recently inaugurated the first independent county campaign in Connecticut to raise funds for the medical schools.

The drive was started with a mailing to all physicians in the county the latter part of September and

within the first ten days returns passed the \$1,000 mark.

The campaign will supplement the 1955 State-wide drive initiated by the AMEF Committee of the State Medical Society last June. Dr Charles E. Jacobson, Jr., Hartford and Manchester, is chairman of the county committee in charge of the campaign and committee members are: Walter P. Kosar, Hartford; Andrew J. Canzonetti, New Britain; Henry M. Pollock, Jr., Bristol.

First New Member Indoctrination Session in Fairfield County

The Fairfield County Medical Association was host to its new members the evening of October 26 at the Stratfield Hotel, Bridgeport.

The occasion marked the first indoctrination session for new members to be sponsored by the Association.

The roles of national, state and county medical organizations were discussed, stressing various committee operations.

Present were spokesmen for the American Medical Association, the Connecticut State Medical Society and the county, including several committee chairmen.

New Recruitments for Residency Training

According to the Council on Medical Education in Hospitals, approval for residency training in professional specialties will soon be limited to hospitals offering full training either independently or in collaboration with other hospitals. The council regards continuity of clinical experience to be of prime importance and makes specific pronouncements with regard to surgical, radiology and urology residencies.

For example, in radiology the following policy will apply: "(1) Effective immediately, hospitals and institutions making initial application for approval of residency training in radiology must qualify for a full three year approval. No new residencies of one or two year duration will be approved unless they are integrated with, or contributory to a fully approved program. (2) All hospitals and institutions approved for residency training in radiology are expected to develop programs offering complete training either intramurally or through affiliation by June 30, 1957."

OUR MEDICAL WORLD

Physicians in this country are in general aware that in many European countries medical care and social security benefits are in some way lumped together and either wholly or partially supported by the state. What they do not appreciate, however, is the chronic insolvency of these systems, which creates recurring financial crises, which in turn lead to desperate measures taken to maintain the level of benefits without bankrupting the insurance associations and the government. Even the longest established schemes are in a state of flux with regard to policy and administration. No government has the courage, and in most cases not even the power, to face an increase in the contribution made by the insured (which already in many cases is oppressively high). Consequently, the real nature of the benefits is reduced by lowered standards of care and administration, and the share of physicians in the funds expended becomes progressively smaller. Two examples will illustrate the unfavorable conditions which exist today in countries which were among the first to inaugurate these insurance schemes.

Germany

German sick funds were inaugurated in 1882 under Bismarck to provide help to the totally disabled sick employee. By 1884 all those with acute diseases were covered. At the beginning, expenses other than fees paid to physicians amounted to 50 per cent of the income of the sickness funds. Although the doctors' share in these funds had decreased to only 42 per cent by 1925, it is now down to about 21 per cent. This has been accomplished largely by adding the families of insured persons without any increase in income in 1930, and subsequently adding assistance for pregnant women, war veterans and first-aid treatment for accidents, all without additional fees.

In 1941 all restrictions on income were withdrawn from the terms of membership. When the fees for sick funds, pensions, and unemployment insurance were lumped together in 1942, individualized medical fees had to be abandoned. All parties concerned fear to ask more payment from the insured, and further efforts are being made to reduce the physicians' share in the funds.

Only about 40 per cent of the approximately 80,000 physicians in West Germany today are employed by the sick funds. The majority of the remainder work in hospitals leaving about 12,000 almost equally divided into three groups; those practicing but with no sick fund patients, those engaged in research or governmental medical office, and those unable to practice or employed in other professions.

In 1954, it was reported to the World Medical Association that the ratio of physicians to population in Germany was 15 to 10,000, second highest to Austria with 17 to 10,000 in Europe, and higher than the United States which ranked fourth in the world with 13.3. Although this high ratio is partly due to immigration of physicians from the East, particularly the 2,800 from East Germany, it had its origins when many young men turned to medical studies during the depression after the first World War, and subsequently when many were forced into medical schools by the Nazis during the second World War. There is actually no over-supply of physicians, but the general unwillingness and lack of ability to pay for medical care of the people of West Germany has resulted in economic hardship for the majority of physicians.

Belgium

Free mutual associations for sickness insurance run by private boards of directors and limited by the financial capacity of the group have existed in this country for over 100 years. They did not cover loss of salary. There are three major political parties in Belgium, Socialist, Catholic, Liberal. As a method of political propaganda these parties created their own mutuals and formed a fourth Professional Federation, which was later joined by a Mutual Federation of societies, which wished to preserve their social and political independence.

By the time Germany introduced compulsory insurance in 1884, the government had begun to subsidize the federations in order to promote extensions of free sickness insurance. The Socialists declared themselves in favor of state control and a single fund for Belgium. The Catholics and Liberals eventually accepted a modified proposal, which was

prevented in its passage only by the advent of war in 1914. Free mutuals with state subsidy grew so rapidly after 1918 that there was no further move for compulsion until 1939.

During the occupation, a Committee including representatives of industrial organizations and union delegates was secretly organized to formulate a "social pact." Only three months after liberation, and without any debate in parliament, a modified version of this plan was promulgated by the Regent as an administrative decree. All those receiving salaries except those holding social security guarantees equivalent to health insurance (public administrators and railroad employees) were included by compulsion regardless of age, sex, income or financial status. The insurance agencies responsible were the Federations as grouped before the war, plus regional offices established by the government for the 43,000 who did not wish to join the mutuals.

The "withholding deduction" is paid by the employer out of the worker's salary. A differential is set up between mine workers, laborers and other employees as a result of which the fund obtains nearly 7 per cent of that portion of laborer's salaries, which is below 5,000 francs a month (the withholding "ceiling"), 5.8 per cent of other employees' salaries below that figure, and 6.64 per cent of the total salary of mine workers. The state contributes an additional 16 per cent of the total sum obtained from salary deductions, operates a special fund for mine workers' accidents, since 1949 has had a special subsidy for mine workers' insurance equal to 50 per cent of their contributions, and subsidizes payments for unemployment.

In spite of all these contributions to the National Sickness and Disability Assurance Fund (FNAMI) in 1951 the government was forced to make up over 130 million francs out of a total insurance deficit of 357 millions. Originally 10 per cent of the receipts were to serve for administrative expenses and 10 per cent for reserve. In 1945 when the scheme started with a probationary period for new members, a large reserve was created, and in 1946 there was a slight profit. In 1947 demands for all services increased (ordinary prescriptions by 41 per cent and special ones by 63 per cent) so that there was a deficit of 1.65 francs for each insured. In 1949 there was a deficit of over a billion francs. Payments pro rata were dropped in favor of payments made on the basis of estimated sickness, the administrative and reserve allocations were forgot-

ten, and the insurance companies were ordered to increase their reserves. By 1952 the deficit had increased even more. In 1954 the Catholic government was succeeded by a Liberal Socialist Coalition, which promptly attacked the doctors for the failure of the program.

Under the medical phase of the plan, free choice of physician is provided. Basic fees are fixed by ministerial decrees, but fees are theoretically free. The High Commissioner for Social Security fixes the rate of fees for which the insuring organizations are responsible, and control is exercised by doctors chosen by the insurance organizations. Fees in most hospitals and clinics are the responsibility of the patient himself.

Recently physicians have organized a nonprofit Physicians National Service to which 4,000 out of 7,000 practitioners in Belgium have pledged support. The object is to provide medical care at low cost to persons of moderate means. The contracts bind the physicians to charge persons of modest income the fees set by the ministerial committee of the National Fund, specifically to those whose family income does not exceed 100,000 francs a year, plus 8,000 francs for each nondependent in the household, and to all miners regardless of income. It also provides a bureau for the settlement of costly fees which is supposed to aid the person without funds secure the surgeon of his choice.

Hats Off!

The naming of Albert W. Snoke, M.D. as president-elect of the American Hospital Association adds one more name to the Connecticut list of distinguished leaders in the hospital and related fields. Dr. Snoke, director of Grace-New Haven Community Hospital, is currently president of the Connecticut Hospital Association.

Agnes Ohlson, chief, Connecticut Board of Nursing Examiners, is president of the American Nurses' Association. Francis J. Braceland, M.D., director of the Institute of Living, Hartford, is president-elect of the American Psychiatric Association. Ira V. Hiscock, Sc.D., professor of public health, Yale University, is president of the American Public Health Association. Miss Lucille Refshauge, director of dietetics, Hartford Hospital, is president-elect of the American Dietetic Association.

NEWS FROM WASHINGTON

Private Physician Payment for Polio Vaccine

The U. S. Public Health Service has announced that the private physician may be paid for vaccinations out of U. S. grants for administrative costs when he performs the service as "an employee or agent of a public agency . . . in carrying out a public vaccination program." Thus payments are authorized even though the public clinic may be conducted in a physician's office, rather than in a school, town hall or other community building. In this case the physician is regarded as an "agent" of the public body sponsoring the campaign, and he may be paid on a per diem or a fee basis. However, if the State intends to use this system for part of its public program, it must so declare in its State plan submitted to PHS in Washington for approval.

AMA Announces Employment of PR Counsel

Our own Dr. Murdock is authority for the statement that the Board of Trustees of the American Medical Association has employed the firm of Borzell & Jacobs, Inc., Chicago, as public relations counsel. The agency will assist the AMA Public Relations Department in the general conduct of its program.

39 States Ready for "Waiver of Premium" Program

A total of 39 States, plus the District of Columbia, Hawaii, and Puerto Rico, have entered into agreements with the U. S. Department of Health, Education, and Welfare to carry out the "disability freeze" program of the social security act. Under this plan, enacted last year, the pension a disabled worker would receive at age 65 is "frozen" or not reduced because of the years he is unemployed. Most States have selected their vocational rehabilitation agencies to operate this program. State officials are in immediate charge of administering the program, but subject to federal review and investigation.

The same machinery being used for administering

medical examinations under the new "disability freeze" law will be used to handle the compulsory disability insurance program if that plan is enacted next year. Under the proposed legislation the disabled worker would get his pension at age 50, rather than waiting until age 65. Federal disability insurance is opposed by the AMA because (a) machinery at the federal level to supervise the certification of disability would project the government into the medical practice picture, (b) cash disability benefits would be a threat to the rehabilitation program, and (c) physicians would be under pressure from patients to make certifications of disability.

Labor Planning Big Push for Disability Insurance

While AMA is making careful preparations for its forthcoming battle against enactment of permanent and total disability insurance, an equally determined campaign is planned by organized medicine's most stubborn opposition, organized labor. Impending merger of American Federation of Labor and CIO calls attention to the role which this big unified body may be expected to play in trying to achieve legislative adoption of disability insurance as a social security benefit.

Nelson H. Cruikshank, AFL director of social insurance activities, writes in *The American Federationist* for October: "The fight for adding disability protection to social security may well be the first major test of organized labor's new strength in 1956." His article in AFL's official magazine casts doubt on AMA's future effectiveness in swaying sentiment on Capitol Hill; cites importance of law's new "disability freeze" provision as a preliminary to approval of disability payments; stresses that coverage of Federal employees, military personnel, veterans and railroaders demonstrates that Washington can successfully administer a program of this kind, on a multimillion, national scale.

Workers' Health Benefits and Coverage Increasing

Rapid growth of medical care and hospitalization insurance for wage earners, under collective bar-

gaining agreements, is described in special report appearing in September issue of *Monthly Labor Review* published recently. Prepared by Evan Keith Rowe, industrial relations expert in Bureau of Labor Statistics, the article gives an impressive statistical picture of the rise of health insurance as a fringe benefit. Among highlights of this detailed report on MLR, official publication of Department of Labor:

In early 1954, some 11 million Americans worked under contracts which provided for medical and hospital benefits. This represented a 55 per cent increase over the 1950 total.

Contractual inclusion of major medical expense, or "catastrophic illness," clauses is becoming more common. Also such liberal features as out-of-hospital diagnostic and laboratory fees and home and office visits by the physician.

Sixty-two per cent of the 11 million workers made no contribution toward cost of health insurance, as far as their own coverage was concerned. Even in plans where benefits were extended to workers' dependents, 38 per cent of the employees paid no part of the cost. In this category, statistics were obtainable on only 7.5 million workers.

Folsom Warns Against Social Security Excesses

Marion B. Folsom, formerly undersecretary of the treasury, succeeded Mrs. Oveta Culp Hobby as Secretary of the Department of Health, Education and Welfare on August 1. Mrs. Hobby is retiring because of the illness of her husband, whose position she will assume as president of the *Houston Post*. Mr. Folsom, 61, came to the Eisenhower administration from the Eastman Kodak Co., where as treasurer he was active in setting up that company's retirement system. He has been interested in social security, and played a part in recent changes in the law. In the last Congress he headed a Treasury task force that worked with Congress to revise the internal revenue code.

In the opinion of Secretary Folsom, "there is a limit to the social security taxes the people may be willing to pay." He sounded the warning against unsound expansion in a talk delivered recently on the work and objectives of his Department of Health, Education, and Welfare. He declared:

"Our social security system has remained sound because Congress has rejected proposals that might

weaken or destroy it. We must always be careful that proposals for new benefits will preserve the essential justice and strength of the system. We must remember there is a limit to the social security taxes the people may be willing to pay to support the system in all the years ahead."

Mr. Folsom commented that the social security system now is "in pretty good shape," but added that "we must always be willing to adapt the system to meet changing conditions and to make needed improvements." In describing the "fundamental spirit" in which he believes changing health and welfare needs should be approached, Mr. Folsom declared: "I hope we will never accept the philosophy that the one and only best answer to every one of our problems and needs is automatically more and bigger federal government. There should be federal concern, yes. But the people should always consider whether it is federal action that is most needed, and whether federal action actually would be the most effective. The people should consider whether individual effort and private enterprise, or local or State government close to the people, can accomplish more real and long range results for all of us . . ." The talk was delivered at a building dedication ceremony at Syracuse (New York) University.

Revenue Bureau Summarizes Medical Expenses Under Tax Law

Deductible and nondeductible medical expenses for income tax purposes have been summarized by the Bureau of Internal Revenue in a series of rulings that combine new interpretations with a clarification of old rulings. Some examples:

Travel expenses to and from a location where daily visits to a medical clinic are required are deductible but (since 1954) cost of food and lodging are not, except as part of a hospital bill. On education and training, special instruction in speech and lip reading for a deaf child are deductible expenses, but not a course of ordinary instruction. Psychiatric care and therapy at specially equipped treatment schools for alleviating mental illness are deductible items, but where cost of instruction at a psychiatric school doesn't represent medical care, it is not deductible. On health and accident indemnity insurance, if a policy covers both injury indemnity and medical expense reimbursement, premium cost for

latter is deductible but not for former. On other points, ordinary exercise rubdown, air conditioner, oxygen equipment, iron lung, special bed board, all are deductible items when prescribed by a physician for an illness, but not food for ulcer patient, maternity clothing, diaper service, wigs or toothpaste.

500 Interns Chosen for Residency Deferments

Announcement in September by Assistant Secretary Defense Frank B. Berry says that 500 medical interns have been nominated for draft deferment which would enable them to begin residency training next summer. Local draft boards actually have the last word, though it is virtually certain that all 500 will obtain deferment, provided they apply and are acceptable for Reserve commissions in one of the armed forces. Defense Department says the 500 were chosen from 1,300 applicants for residency deferment. Another 1,200 preferred to serve their obligated military service before entering upon any postgraduate study.

Last July approximately 300 young physicians started residencies as draft deferred special registrants, under the Berry plan.

7 Point Cigarette Guide Inhibits Medical Claims

Federal Trade Commission, plagued for years by exaggerated advertising claims for cigarettes, has adopted a 7 point guide for use of its law enforcement agents. Mainly the rules are concerned with medical and health angles. FTC gives warning it will frown on (1) representations of physical effects of smoking; (2) unsubstantiated claims that one cigarette contains less nicotine, tars and other substances than competing brands; (3) statements that tie in cigarette smoking with welfare of respiratory tract, digestive system, nerves or energy; (4) claims that smoking in general, or use of any particular cigarette, carries medical approval of any sort.

Other parts of the guidelist censure false or inaccurate representations on sales volume; spurious testimonials, and advertisements falsely or misleadingly disparaging rival brands.

FTC Agreements Restrict Drug Advertising Claims

Federal Trade Commission has terminated two more cases involving questionable advertising of self-medication products. Stipulations have been signed with firms in Chicago and New York by which they agree to cleanse marketing claims in behalf of "ViViBx (Formula No. 56DX)," as a treatment for arthritis and rheumatism, and "Edanol," a vitamin compound beamed chiefly at middle aged males seeking rejuvenation.

FDA Revises Regulations Covering Release of New Drugs

Revised regulations issued by Food and Drug Administration regarding the release of new drugs more clearly define the responsibility of both manufacturers and FDA. The regulations, developing out of recommendations of a citizens advisory committee, become effective early in October, unless suggestions from interested parties result in hearings or revisions.

One change is of particular interest to physicians who participate in clinical evaluation of new drugs during the investigation stage. In the future FDA will have authority to require the manufacturers to supply all information on shipments of investigational drugs to physicians, and to require the physician to sign a statement describing the nature and results of his experimental work with the new drug. A spokesman said FDA wanted the additional authority to be able to cope with a few situations and that the change was not a reflection on the drug industry as a whole or the physicians who regularly carry on clinical work for manufacturers. Other changes include: 1. Drug houses will be permitted to file an "incomplete application" over the protest of FDA's New Drug Branch, to be followed promptly by a hearing and court action if the producer so desires. 2. FDA is required to notify applicants by letter of any deficiencies found in preliminary review of the application, thereby avoiding long delays in making changes in the product or its processing. 3. The manufacturer in the future will be required to show on his application any information (derogatory) developed in the tests for the safety of the drug.

Fairfield County Medical Association Goes to the Fair



Photo by Clarence F. Korker

Members of the Fairfield County Medical Association went to the Danbury Fair October 1-9 to talk with the people about health protection.

Using an attractive exhibit obtained from the American Medical Association, their goal was to acquaint fairgoers with the dangers of excess weight and what to do about it.

In this picture, Dr. D. Olan Meeker, Riverside, second from left, sets a scale for a young man concerned about his weight.

Members of the Woman's Auxiliary to the Fairfield County Medical Association assisted in managing the exhibit, which attracted thousands of the 143,000 persons who invaded Danbury for the event.

Cancer Grants to Yale

Two major grants to Yale by the American Cancer Society came to a total of \$112,814 and brought to \$277,308 the amount assigned to Yale for research in the coming year. With these two grants Yale will be putting to work for ACS research more money than ever before, for an annual period. The new investigation in lung cancer, awarded \$59,314,

will be supervised by Dr. Francisco Duran-Reynals, whose work for many years in the relationship of viruses to cancer has gained national prominence. It is one of eight research programs launched by the national society to get data that can help to check the alarming rise in lung cancer deaths. Dr. Duran-Reynals' research has as one goal the determination of whether external irritants, including

tobacco tars, cause a virus reaction in people, which in turn induces cancer.

This year's institutional grant is in the amount of \$53,500, an increase of \$3,500 over former years. In operation at Yale for the past seven years, the grant pays for medical work carried out directly with patients, and puts into actual use the latest drugs and treatments as well as the most modern forms of diagnosis. The grant is under the direction of Dr. Vernon W. Lippard, dean of the Yale Medical School.

Flood Damage Much Less than Originally Estimated

WATER AND FIRE KNOCKS OUT LESS THAN 6 PER CENT OF STATE'S INDUSTRY

Although actual figures on total damage to industry and business from the August flood will probably never be known in detail, the general outlines are beginning to emerge.

Estimates of damage, collected and compiled by the State Development Commission, indicate that the total losses to manufacturing plants are in the vicinity of \$73 million. This includes damage to and destruction of factory buildings and loss of machines, equipment and inventory. The Development Commission estimates that these losses represent about 5.3 per cent of the total value of factory buildings and machines in Connecticut.

Hardest hit, of course, was the Naugatuck River valley in the Waterbury area. The Waterbury section, as a whole, had damage to industrial plants alone estimated at \$32,393,950. This included 90 industrial plants in Waterbury itself, with nearly \$15 million; Naugatuck, where 16 plants suffered nearly \$11 million damage; Thomaston, with 7 plants reporting \$3½ million loss; and Bristol, where 14 companies showed nearly \$1½ million destruction.

The Torrington area was next, with total losses just under \$16 million. Hardest hit industrially was Torrington itself, with \$8,756,300 damage to 46 factories. Winsted also bore the brunt of the flood, with 25 manufacturing concerns reporting damage estimated at \$4,887,550. The only other community in this area where total damage was more than a million dollars was Collinsville, where losses slightly above the million dollar mark were suffered by only two companies, nearly all of them in a single concern.

Not far behind these regions in industrial damage was the lower Naugatuck Valley near the river's confluence with the Housatonic, including Seymour, Ansonia, Derby and Shelton. These four towns, three of which are virtually a single community, took terrific blows which left few industries unscathed. In Ansonia, 25 factories lost a total of \$7,889,575, and many vital transportation and communications services were washed out as well. In Derby, a dozen plants lost more than \$2 million, and in adjoining Shelton 16 concerns had another \$631,400 in damages. Seymour, a community of only 8,000 population, suffered losses of nearly \$2 million; and these, together with commercial losses, amounted to more than ten per cent of the assessed value of taxable property in the town.

The eastern part of the State suffered extensive damage from an entirely different river system, with the greatest damage in the northeastern corner in the towns of Thompson and Putnam. Thompson, a community of fewer than 6,000 population, had more than \$3 million, nearly all of it chargeable to the total loss of two textile mills by fire, with fire apparatus unable to approach the blazes because of flooding. Putnam had more than \$2 million losses, spread among 14 concerns, including two textile mills which accounted for 75 per cent or more of the damage, and one metal-working plant which suffered total loss from fire.

COMMERCIAL DAMAGE \$37 MILLION

Damage to commercial properties, although much more highly publicized than industrial damage, amounted to about half the dollar loss assessed against industrial properties. For the entire State, it was estimated that damage to wholesale and retail businesses amounted to about \$37 million. Heaviest damage here, as in the industrial destruction, was in the Waterbury area and the middle Naugatuck Valley, where there was a \$20 million loss to commercial concerns, more than \$14 million of it in Waterbury proper. Incomplete figures for the Ansonia-Derby area showed more than \$7 million, and this will actually rise much higher.

Hard hit as well was the Torrington area, including Winsted, where whole blocks of retail businesses were extensively damaged and stocks damaged beyond possibility of salvage. The retail business losses in this area were more than \$7 million.

The Hartford area was the only other section where trade losses added up to more than a mil-

lion—the figure approximating \$2 million, with the town of Farmington suffering the greatest loss, with \$728,255 damages, largely concentrated in the Unionville section.

The eastern Connecticut area which was hard hit industrially had just under a million dollars commercial damage reported, with Putnam having the largest loss, estimated at \$522,525.

With very extensive damages to public utility facilities not yet assessed, the dollar loss resulting from the flood in Connecticut has been estimated at \$200 million, including the industrial and commercial losses mentioned above, and also losses to farms, schools, highways and bridges. It is now apparent that even with more complete figures available, the totals will be well below the estimates made during the first shock of the disaster.

PRODUCTION RAPIDLY RESTORED

The restoration of plants and machinery proceeded at an amazingly rapid rate, with employees cheerfully accepting all sorts of unaccustomed tasks, including the shovelling of silt from flooded factory floors; and with amazing cooperation between manufacturers facilitating the restoration job.

The work of resuming production in many plants after the knock-out blows by the appalling forces of surging waters cannot be measured statistically, or in any other terms than those of human courage and determination. The degree to which recovery from this great natural disaster has taken place can be seen in part, however, from the record of unemployment, as shown by applications for unemployment compensation.

The immediate effect of the floods which battered factories with flotsam and flooded them with polluted waters was to throw out of work an estimated 70,000 persons from an industrial employed list of 410,000, or 17 per cent of the total.

Within a week, nearly half of these workers were again employed, most of them on clean-up work. One month after the disaster it was estimated that the number of industrial workers still unemployed whose jobs had been lost due to the flood was down to 6,000. An additional 7,700 were working at other than their regular jobs for other employers. The State Labor Department estimated that 9,900 were still on clean-up work for their regular employers at that time. The totally unemployed in manufacturing (6,000), then, constituted 1.5 per cent of the total factory employment.

Connecticut Committee on Foods, Drugs, Cosmetics and Devices Meeting of July 28, 1955

The member societies and institutions were represented at this meeting as follows: Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut Pharmaceutical Association, Prof. Nicholas W. Fenney; Connecticut State Dental Association, Dr. William Kirschner; Connecticut State Medical Society, Dr. Barnett Greenhouse; Connecticut Veterinary Medical Association, Dr. Joseph DeVita; University of Connecticut College of Pharmacy, Dean H. G. Hewitt; Yale University School of Medicine, Dr. Desmond D. Bonnycastle.

The following were also present: Dr. Felix Blanc, representing the Pharmacy Commission; Dr. Hugh Dwyer, former representative of the State Medical Society; Mr. Herbert Plank, representing the Food and Drug Commission.

"SCOTTIE DETERGENT-SANITIZER"

Mr. Plank reported that a case of a child being killed as a result of drinking a household preparation had arisen since the last meeting. A thirteen month old child (Craig Wachter) had climbed onto a table and swallowed an unknown quantity of "Scottie Detergent-Sanitizer" with which his mother had been washing the floor. The boy had immediately begun to vomit, and was rushed to the Norwalk Hospital, where the interns did not know what to do, but finally washed out the stomach and gave drugs to quiet the convulsions. At first they had thought the boy was going to be all right, but shortly his breathing became rapid, his blood pressure went up, he started hiccuping and then stopped breathing. The autopsy showed a pulmonary embolism—the nerves paralyzed. Plank said he had a call from the manufacturer, a Mr. James Scott, who at first tried to blame the death on a "Coca-Cola" that the child had drunk before he swallowed the "Scottie Detergent-Sanitizer;" later Scott said his preparation was very similar to "Roccal," and admitted he had heard a man had died from drinking "Roccal." Plank added that the doctor suspected blocking of the ganglia as the cause of death.

In the discussion that followed, Dr. Dwyer pointed out that gangliar blocking had not been proved but was only a hypothesis, and Dr. Bonnycastle stated that not too much was known about the physiological effects of quaternary ammonium compounds and that he would not know offhand what antidote to recommend.

Mr. Plank displayed a bottle of the preparation, and Dr. Fisher pointed out that it had been deliber-

ately made attractive to small children by a picture of a Scottish Terrier on the label and a small plastic figure of a dog hanging from a chain around the neck of the bottle. The product was labelled as "A Highly Concentrated Disinfectant Deodorant Cleanser," and bore the following ingredient statement:

"Active Ingredient: Alkyl (C_9 - C_{15}) tolyl methyl trimethyl ammonium chlorides—5 per cent.

"Inert Ingredients: Water, special grease removing detergent, perfume, colorant—95 per cent."

The only warning statement was the following: "Caution: Avoid Contamination of Food. Do Not Use With Soap."

The manufacturer's name was given as "Scott Chemical Company, Fairfield, Conn."

Dr. Fisher reported that analysis in his laboratory had shown 5.14 gm/100 cc. of quaternary ammonium compounds, confirming the declared 5 per cent; this was half the strength of "Roccal," and unusually concentrated for a household preparation. A letter of July 22 from Mr. Scott to Mr. Plank quoted data from Rohm and Haas on the toxicology of their "Hyamine 2389," which was the active ingredient of "Scottie Detergent-Sanitizer." According to their statements the LD_{50} to rats of "Hyamine 2389" was 350 mgm/kgm; since "Scottie Detergent-Sanitizer" contained 5 gm/100 cc. of this compound, which is 1,479 mgm/fl. oz., 2.37 fl. oz. should almost certainly kill a 20 lb. baby.

Dr. Fisher noted that because "Scottie Detergent-Sanitizer" was labelled as a disinfectant it was a drug under the Food, Drug and Cosmetic Act; it also came under the Insecticide Law. Since it was labelled with the percentages of active and inert ingredients as the Insecticide Law required, and since neither (State) law required naming an antidote, the only apparent law that was violated was that section of the Food, Drug and Cosmetic Act which required "adequate warnings against use . . . by children where its use may be dangerous to health." It had to be admitted that even if the hazardous substances bill had been passed and in effect it would not have covered the present case, because the bill exempted products coming under the Food, Drug and Cosmetic Act and the Insecticide Law.

THE HAZARDOUS SUBSTANCES BILL

There was some discussion of certain details of the unfortunately unsuccessful campaign to get the

Legislature to adopt the hazardous substances bill. During this discussion Dr. Fisher called the members' attention to the fact that some people had been given an erroneous impression as to the amount of revision the bill had undergone between its first introduction on January 28 and the close of the special session of the General Assembly. While there had been quite a number of bill numbers, most of these represented textually identical bills introduced in different houses at different times. There were actually four different texts:

(1) The original skeleton bill which (as was stated at the January 27 meeting) was introduced only to meet the legislative deadline with the definite understanding that it would be replaced by a complete bill.

(2) The original bill drawn up by our subcommittee (House Committee Bill 1887).

(3) A revision of House Committee Bill 1887 incorporating changes suggested by the manufacturers at the hearing on April 27.

(4) A revision in form only made by Legislative Commissioner Wall.

Dr. DeVita announced that he had already been in touch with the Legislative Commission concerning their study of the bill, and that for the next year and a half while the General Assembly was not in session our activities would by necessity be confined to: (1) placing our case before the Legislative Commission; (2) giving publicity to any poisoning cases that developed; and (possibly) (3) conferring with representatives of the manufacturers in an attempt to secure their acceptance of a text that we could approve of.

Dr. Lee D. van Antwerp, Chicago, Honored

Dr. Lee D. van Antwerp of Chicago, nationally known medical editor, has been honored as recipient of the 1955 Distinguished Service Award given by the American Medical Writers' Association. Dr. van Antwerp is medical editor of G. D. Searle Co., medical director of G. D. Searle International, the 1955 president of the American Medical Writers' Association and former editor of the Association's Bulletin.

The Distinguished Service Award is given annually to a member of the Association, "who has made distinguished contributions to medical literature or rendered unusual and distinguished service to the

medical profession." The award, comprising a plaque and a gold medal, was presented to Dr. van Antwerp by the new president of the Association, Dr. Richard M. Hewitt, of the Mayo Clinic, at the banquet held on the occasion of the 12th Annual Meeting, at the Hotel Jefferson, St. Louis, September 30.

Dr. van Antwerp was formerly a member of the editorial board of the *CONNECTICUT STATE MEDICAL JOURNAL*.

Connecticut Academy of General Practice

A new bulletin is now being prepared for publication by the Connecticut Academy of General Practice. This bulletin will edit news of interest to members of the Academy of General Practice. The committee in charge of this publication will be headed by Daniel N. Markley of Hartford as editor. The following men will serve with Dr. Markley: Edwin Trautman, Trumbull; Richard Elgosin, Hamden, and Peter Scafarello, Hartford.

During the past year the following men have been admitted to active membership of the American Academy of General Practice and its component State chapter: Vincent Balletto, East Haven; G. S. Gudernatch, Sharon; Irvin M. Israel, Colchester; Jerome O. Kirschbaum, Middletown; Alfred Owre, Jr., Madison; Robert F. Buckman, Milford; Donn C. Barton, Middletown; Leo P. Giardi, Hartford; Yale Gordon, Elmwood; Arthur V. McDowell, Cromwell; Waldo E. Martin, Milford; Henry Zalichen, Stamford; Arthur D. Keefe, West Hartford; Lee J. Whittles, Glastonbury; James E. Stretch, Simsbury; James V. Calio, Hartford; William T. Corbett, Trumbull; John L. Sullivan, Bridgeport.

News from American Medical Association: "The AMA to identify general practitioners."

Members of the American Academy of General Practice will be so identified in the new directory of the American Medical Association to be published in 1955. This is the first time the special status of the general practitioner has been acknowledged in this international reference book.

Thomas J. Danaher, chairman of the Connecticut Medical Service Professional Policy Committee, has advised the several county medical associations that the vacancies on the committee to be filled at the next annual meeting of the Board of Directors are: obstetrics and gynecology, general practice, internal medicine.

Dr. Carl Peterson Fatally Injured

Dr. Carl M. Peterson, secretary of the AMA Council on Industrial Health since it was organized in 1938, was fatally injured on September 26 when a private plane in which he was riding with the pilot and co-pilot crashed and burned on a farm near the Asheville, North Carolina, airport.

The crew was killed instantly. Dr. Peterson, who was 55, was taken to the new Pardee Memorial Hospital at Hendersonville, N. C., with extensive burns, a fractured leg, several fractured ribs, and possible internal injuries. He had excellent medical care. Several hours after the crash physicians attending him thought he would pull through, but within 24 hours his condition suddenly became worse and he died on Tuesday, September 27. One of his sisters was at his bedside.

Dr. Peterson, who first came with the AMA as a hospital inspector in 1930, had been in Houston, Texas, for the Southwest Industrial Health Conference. He left there on Sunday, the 25th, aboard a commercial airliner and landed at Atlanta, Georgia. Before leaving Houston, he had arranged with Dr. Logan Robertson, prominent Asheville industrial surgeon, to ride a private twin-engine Beechcraft from Atlanta to Asheville.

Dr. Peterson was asleep in the plane with his safety belt unfastened at the time of the crash. Somehow, he was thrown out of the plane, but, unfortunately, not far enough to escape the flames. Under Dr. Peterson's own direction, Alfred Dalton, who lives on a farm at the foot of a mountain where the crash occurred, and his brother-in-law, W. R. Hendrix, tore their shirts and jackets into strips and tied Dr. Peterson's badly broken leg with splints. Then they took him to the hospital. Witnesses said that Melvin Sam Gould, the pilot, was trying an instrument landing at the time of the crash.

Dr. Peterson is survived by five sisters and two daughters, Natalie, 20, a student at Wellesley, and Judith, 17, a high school student in Palatine, Illinois, where the family lived. Mrs. Peterson died in 1950.

Out of respect to Dr. Peterson, the Fourth Conference on Medical Care in the Bituminous Coal Mine Area, scheduled to be held on October 2 in Charleston, West Virginia, was cancelled.

**PLAN TO ATTEND THE AMA
CLINICAL SESSION IN BOSTON
NOVEMBER 29 - DECEMBER 2, 1955**

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Norman J. Barker, Collinsville

President-Elect, Mrs. E. Roland Hill, Mystic

First Vice-President, Mrs. Charles Murray Gratz, Cos Cob

Second Vice-President, Mrs. Morton Arnold, Windham Center

Recording Secretary, Mrs. Charles Culotta, Hamden

Corresponding Secretary, Mrs. James E. Stretch, Simsbury

Treasurer, Mrs. Joseph Cutler Woodward, South Lyme

The September, 1955 issue of the *Bulletin* of the Woman's Auxiliary to the AMA contains the program of the Public Relations Committee written by its chairman, Mrs. F. Erwin Tracy of Middletown, and the report of the Connecticut President for 1954-1955, Mrs. Newell W. Giles of Darien.

The semi-annual meeting is scheduled for November 15 at the Hartford Golf Club. Mr. R. G. Van Buskirk, secretary of the Committee on Legislation for the AMA, will be the speaker. Mr. Van Buskirk is a lawyer and a member of the staff of the Association's legal department. He is noted for making legislative questions clear and interesting for his listeners. On the entertainment side, Hank Keene will entertain the group after luncheon.

School of Instruction

A School of Instruction was held on September 12. Mrs. F. Erwin Tracy, national chairman of Public Relations, addressed the group. She mentioned the following aids for doing auxiliary work and said they have proved helpful to her:

1. Attend a national convention for inspiration, information and education. It is the democratic process of our country in operation.
2. Attend State meetings. Engage educators, public men and physicians from Connecticut as speakers.
3. Attend county meetings. Take part in the discussions. Counties should carry out the Auxiliary's purpose in its program planning.
4. Use the medical advisory committees; consult them and invite them to meetings.
5. Be cautious about using Auxiliary's name when expressing personal views, as in writing Congressmen. All chairmen should send carbons of their correspondence to the county president.
6. Read your mail and answer it promptly.
7. Read, read, read to keep up with what is happening in medicine.

8. Program and public relations chairmen should work together.

After luncheon summaries were presented by the round table participants. The county presidents suggested we make full use of the Handbook; remember new members and give them a job to do; attend State meetings; make full use of and become familiar with all the material that comes from National. The program committee suggested we have cooperation among all county committees; have suitable programs which include information on community health, rural health, AMEF, Civilian Defense. Public relations stressed AMEF and county fairs. There should not be too many projects during the year. AMEF committee wants to work with the program chairmen and the ways and means committees of each county. Suggested that each county budget include an item for AMEF. Civilian Defense has as its goal "protected homes" for at least 10 per cent of the membership. These homes should have their bomb shelters photographed as an example to the membership. Home Nursing and First Aid course graduates should be listed; members should be registered Civilian Defense workers. The program committee suggested that counties should include on their programs at least one of three major topics: child health studies, rural health and safety; should have a Civilian Defense meeting early in the year; should emphasize the needs of medical schools and the necessity of supporting them through contributions to AMEF.

President's Report

Mrs. Norman Barker attended the combined annual meeting of the New Hampshire and Vermont Auxiliaries held at the Mount Washington Hotel, Bretton Woods. It was the 30th annual meeting for New Hampshire with a membership of 377, and the 6th annual meeting for Vermont with a membership of 175. Mrs. Mason G. Lawson, national president and Mrs. Robert Flanders, national president-elect

were speakers. Mrs. Lawson stressed the tremendous progress that the Auxiliary has had and is achieving as an organization dedicated to community service in health.

Mental Health

The national Mental Health Committee has outlined a broad program which includes five areas of activity: education, legislation, philanthropy, research and service. Mrs. Richard Karpe, State chairman, believes that for Connecticut the educational area is most practical. Copies of the outline have been sent to county presidents and the county Mental Health chairmen and Mrs. Karpe plans a discussion of this material.

County News

MIDDLESEX

Middlesex County held its semi-annual meeting on October 13 at Restland Farms. It was an afternoon meeting at which Mrs. Norman Barker spoke. The membership was then invited to dinner with the Middlesex County Medical Association.

The November 1 meeting, held at the home of Mrs. Harry Knight, was devoted to the American Medical Education Foundation. Dr. Knight was the speaker, and Mrs. Mark Thumim, AMEF chairman, had the AMA film, "Danger at the Source" shown.

NEW HAVEN

The first meeting of the fall season was held at the Connecticut State Hospital in Middletown and included a tour of the new occupational therapy department. Members were invited to attend a Volunteer's program at the hospital.

Mrs. William Richardo set up booths and saw that they were covered at the 4H Club, the North Haven County Fair and the Guilford Fair.

Mrs. David McGaughey, county president, spoke to the Waterbury Auxiliary in October concerning the work of the Woman's Auxiliary to the New Haven County Medical Association.

NEW LONDON

A Nurses Scholarship and Welfare Fund Bridge was held October 4 at Lighthouse Inn, New London.

At the semi-annual luncheon meeting held October 18, Dr. William J. Murray, Jr., spoke on the Diabetic Drive in the community. Mr. Rodney Scott from Sillberman's was the main speaker.

Mrs. Rasmussen of Nurse Recruitment reports that \$300 has been sent to the Lawrence Hospital School of Nursing upon the request of the Director, Miss Blair.

The Board has moved to set aside \$50 over and above the profits from the Dinner-Dance as New London's contribution for 1955-56 to the AMEF.

Members are volunteering to help with the Annual Diabetic Drive by collecting specimens, testing them and helping to publicize the drive.

WINDHAM

At the first meeting of the Board of Directors it was unanimously voted to increase the county's contribution to AMEF.

The fall meeting, held on October 20, had Civil Defense as the feature of the program.

Manuscript Editing Service of American Medical Writers' Association

Theodore Peterson and Harold Swanberg at the recent St. Louis meeting of the American Medical Writers' Association emphasized the splendid accomplishments of the AMWA Manuscript Editing Service (Headquarters, W.C.U. Building, Quincy, Illinois). This service recognizes that most physicians are poor writers. It was initiated in 1952 to help improve the quality of writing in papers (5,000 words or less) submitted to medical journals. It is primarily designed to help the author to express himself accurately and with grace, precision, emphasis and economy. A written report is prepared for each manuscript giving a running commentary which, line by line, paragraph by paragraph, calls the author's attention to his errors in writing and suggests alternate phrasing. It is a noncommercial service and operates at a low fee. It will not accept material which will be sold, neither does it compile bibliographies, nor do ghost writing. It aims to help carry out Sidney's Smith's adage, "The writer does the most who gives the reader the most knowledge and takes from him the least time."

State Cancer Campaign Breaks Record

Contributions from Connecticut citizens to the annual cancer fund appeal this year reached a record breaking figure of \$575,825. This was more than \$100,000 over the goal set. An impressive per cent of districts and towns went well over the assigned quotas.

OBITUARIES

Robert Ellsworth Peck, M.D. 1866 - 1955



Robert Ellsworth Peck died in Concord Hospital, Concord, New Hampshire on July 6, 1955, at the age of 88, after being confined to the hospital for about nine months suffering from malignancy of prostate with generalized metastases.

Dr. Peck was born in New Haven, attended the New Haven Public Schools and Stowe Military Academy; graduated from Yale in Class of 1890 Sheff., received his M.D. from Yale in 1893.

After a few years of general practice, he became interested in neurology and was Instructor in Neurology in Yale Medical School and Chief of the Neurological Clinic at New Haven Dispensary from 1898 to 1907 when he resigned.

In 1908 he opened the Peck Sanitarium in Woodmont, Connecticut for the care of nervous patients and continued to operate this sanitarium until 1943 when he disposed of it.

In 1913 he became Director of Physical Therapy at Elm City Private Hospital and in 1920 assumed charge of the Physical Therapy Department at Grace Hospital. He also assumed charge of the Physical Therapy Department at Charlotte Hungerford Hospital in Torrington in 1925 where he spent one day each week.

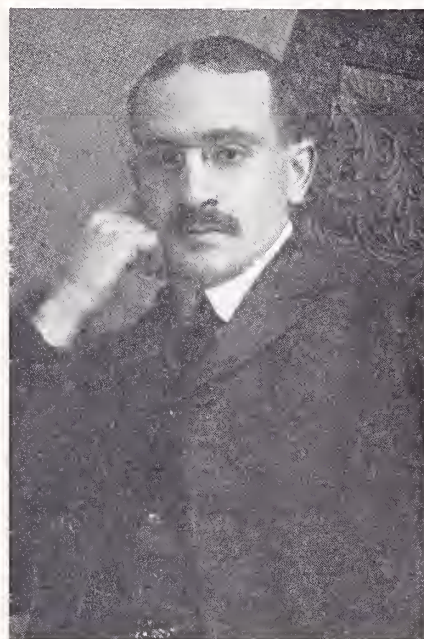
In 1945 he retired from practice, purchased a farm in Dunbarton, New Hampshire, where for almost ten years he devoted his time to organic gardening and found real pleasure in this work.

After living with his mother for many years, he married Eva Louise Seward on December 27, 1928. His first wife died in 1932. On June 28, 1933 he married Jeanne Barrett Goodwin who survives him. There were no children.

Until his retirement in 1945 he was a member of the Graduates Club in New Haven, the Lions Club, the New Haven City, County and Connecticut State Medical Societies. He had been a member of Dwight Place Congregational Church in New Haven for many years and after moving to New Hampshire became an active member of the Dunbarton Congregational Church.

Ralph W. Nichols, M.D.

William Peter Lang, M.D. 1879 - 1955



Dr. William Peter Lang who died July 24, 1955 was the son of the late Peter C. and Bertha Lang. He was born in Philadelphia, February 4, 1879, where he received his early education. He attended Hahnemann Medical College, from which he was graduated in 1901. Following his graduation, he

served at Metropolitan Hospital and the Eye, Ear and Nose Hospital in New York as intern and later as resident in surgery. Before coming to New Haven he did postgraduate work at Heidelberg, Germany, Berne, Switzerland and London, England. In 1907 he opened an office in New Haven. He later married Elizabeth Bascom, who died previously. During his practice in New Haven he was surgeon on the staff of Grace Hospital. Dr. Lang had a very active practice not only in New Haven but also in the neighboring communities, as well as an extensive consulting service in Middletown and Waterbury.

Dr. Lang was a fellow of the American College of Surgeons and of the American Medical Association. He was a member of the State and local medical societies. He held membership in the Connecticut Homeopathic Medical Association, of which he had been the president, in the Pan-American Homeopathic Medical Congress, in the American Institute of Homeopathy, in which he had served as a member of several committees, of the Board of Control and of the Board of Directors. For many years he was a member of the Connecticut State Homeopathic Medical Examining Board, of which he was its president for several years.

Dr. Lang's devotion to his vocation and to his patient's welfare was so great that he spent most of his vacations attending surgical clinics. Following his retirement a few years ago he traveled extensively in this country and abroad, where he had a large number of acquaintances. His interest in these world tours centered about research in cancer.

The patients of Dr. Lang were extremely loyal and devoted because they were inspired by his spirit of faithful fidelity and expert exactness. He was remarkably erudite, incredibly industrious, untiring, patient and absolutely sincere, holding always to singleness of purpose: the relief of suffering.

C. Seaver Smith, M.D.

George G. Keefe, M.D.

1895 - 1955

George Gregory Keefe was born in Waterbury, Connecticut on July 22, 1895, and died at his home in West Hartford on July 21, 1955.

Dr. Keefe was the son of the late Mr. and Mrs. Peter T. Keefe. He was one of ten children. One



brother, Dr. Walter Keefe is a well known ear, nose, and throat specialist in Hartford.

He received his elementary education in Washington Grammar School and Crosby High School in Waterbury. After graduating from Holy Cross in 1918, he enrolled in the University of Maryland Medical School in Baltimore, from which school he graduated in 1922.

He served his internship at St. Francis Hospital in Hartford during 1922 and 1923. He was a member of the Hartford, Hartford County, and State Medical Societies; also a member of the St. Thomas Men's Club and the Holy Cross Club of Hartford.

His wife was the former Amy Casey, and they had four children. One son, Dr. William Keefe, is at present an intern at St. Francis Hospital.

To adequately describe the life of the late Dr. Keefe is to relate the story of the ideal family physician. A conscientious doctor and a sincere counselor, he was held in high esteem by his many patients. His family life could be characterized as a model one. His devotion to his family was well known to his associates. In summation, his life was "a noble one," to use a caption given him by a well known local editor.

We all join in expressing our sincere sympathy to his wife, children, brothers, and sisters in their great loss.

George C. Finley, M.D.

ARE YOU TAX BAIT?

RALPH R. BENSON, LL.B., *Los Angeles, California*

The Author. *Attorney at Law*

This is the first in a series of articles designed to help the physician to be more meticulous in his bookkeeping and thus less apt to encounter difficulties with federal revenue agents.

DON'T jump when you open that letter or when that man in the doorway tells you the Federal Tax Return you filed this year, last year, or even a couple of years ago is being carefully investigated.

You stand there—and right away you hit yourself with this question: "Why did this happen to me?"

You assure yourself that you are an honest taxpayer and have nothing to fear and nothing to hide. Yet, when you signed that tax return you mailed the original with the hope you would never hear of it again and put the copy in your files in the belief it would just gather dust.

Would you like to know about the innocent, homespun, garden variety ways of attracting the attention of the tax people?

It is not just a tax return that attracts attention. It can be your method of keeping books. It may be the people around you that you know or do not know. It may not be anything of your doing that attracts attention. Or the government may snap at first at the simple harmless bait, and then by its procedures, snare a far greater bait and a more explosive one.

Are you interested in learning what these ways of attracting attention are and which of these ways can be avoided?

Then rate your own chances of coming down with a good case of "T.T.'s" (tax tremens) by going through this list of "Bait":

THE BAIT

1. Have you made any mistakes in arithmetic?
2. Did you claim a large or unusual deduction?
3. Are you claiming dependents other than your wife and children?
4. Is your income over \$20,000 a year?
5. Is your return part of a "spot" check?
6. Has your patient been called in to prove up medical expenses on his own return?

7. Has an informer told a story about you?
8. Has a newspaper given you publicity on your finances?
9. What vicious rumors are making the rounds?
10. Is the wife in the divorce court telling all?
11. Has a Federal or State Agency become aroused about you?
12. Will a large amount of cash in your safe deposit box create suspicion after your death?
13. Do you pay your bills in cash?
14. Are you buying property?
15. Will the inventory of an estate show up possible unpaid income taxes?
16. Are you a victim of the bank deposit method?
17. Are you a victim of the net worth theory?

BAIT No. 1

HAVE YOU MADE ANY MISTAKES IN ARITHMETIC?

Take the case of Dr. A, a busy OB man, who had counted on a few free evenings to do his tax return. But instead he let it go until the deadline, the night of April 15. Apparently, delivering babies had caused him to take care of other people's new tax exemptions while he had delayed taking care of his own.

With the clock running out on the last few hours for filing, Dr. A feverishly gets hold of an adding machine and starts listing all of his operating expenses from a stack of torn slips. His office expenses total \$3,600, including \$1,200 for a cleaning woman to whom he paid \$100 per month. Interrupted. He gets a telephone call. A worried patient in false labor. Back to the grind again. Still thinking about his patient's labor pains, he enters the correct total of \$3,600 on the return but copies \$2,100 instead of the \$1,200 for the cleaning woman by simply mixing the figures 1 and 2. This simple error which slipped through his fingers will be picked up by the comptometer operator at the Federal Building, as her nimble fingers punch the busy keys. A simple error paying off in \$1,000,000 worth of grief.

This simple error which happens every day, will automatically summon the doctor into the tax office for explanation. The tax people would not know

from the face of the return whether the \$2,100 or the \$3,600 was the correct figure. Sure, the doctor, after spending a day down at the tax office, after tracking down his receipts, vouchers and check stubs will eventually sweat his way out of the problem and stand pat on the original tax due with no change. But this simple error of one item caused a complete check-up of pages 1, 2, 3 and 4 and all of Schedule C attached.

The moral is: It is standard office procedure for the local tax office to check all returns for mathematical accuracy with its corps of comptometer operators.

So you had better take your time or see your accountant or tax adviser. Besides, an OB man can alleviate labor pains, his patients' and his own, by getting an extension of time for thirty days which is not too hard to get from the tax people.

BAIT No. 2

DID YOU CLAIM A LARGE OR UNUSUAL DEDUCTION?

Dr. B. last year claimed a deduction for \$5,103.52 for entertainment expenses. He operates an industrial clinic. His practice is strictly referral. He contracts with industrial insurance companies to be referred industrially injured patients from several manufacturing plants. The doctor makes it his business to entertain the insurance companies' key men, the executives of the factories and the doctors at the First Aid Clinics, who regularly send the injured employees from the plant to the outside industrial doctors on the approved list. Dr. B, as well as the other industrial doctors in the area, take these people to lunch or dinner or to football games. He invites them to Christmas parties, gives them wedding, birthday and anniversary gifts and invites the more daring on aeroplane and hunting trips. Last year he estimated all these expenses except the Christmas party. He had kept no itemized records and had but one receipt of \$103.52 from the Christmas party and estimated the rest at around \$5,000. This year, on the advice of his accountant, he kept accurate records. He marked the checks when he paid for gifts, with the names of the specific industrial clients. On the lunches, dinners and ballgames where he paid cash, he reimbursed himself the next day by check. All of his aeroplane and hunting expenses at the airports and hunting lodges were by itemized charge accounts and paid monthly. Then the accountant subtracted from the dinners the cost of the doctor's usual meals and from the

aeroplane and hunting expenses he picked out 25 per cent as the doctor's fair estimate of his own personal expenses. The net total this year was a surprising \$9,502, a surprise even to the doctor because he thought he spent the same as last year. His estimates in years before were actually too low. This year Dr. B's return is checked because of the unusually high entertainment deductions in both years.

An unusually intelligent government auditor, of which there are many in government service, reviewing tax returns at the Federal Building would be alarmed at the total business deductions, including entertainment in contrast to the doctor's reported total income. For instance, a deduction of \$9,502 or \$5,103.52 for entertainment against a gross of \$40,000 would attract attention, inspection and visitation. This year's entire itemization clears 100 per cent because it is itemized and necessary and proper to his specialty in his profession. Last year's, except as to the Christmas party, is cut in half by the agent when the doctor fails to produce sufficient evidence to back up his estimates and he is only allowed for last year \$2,603.52.

The moral is: Dr. B now keeps a little black book marking down:

1. Place of entertainment.
2. Kind of entertainment: tickets, food or liquor.
3. Name of entertainees.
4. Amount actually spent on them; and
5. Date.

This goes for every entertainment deduction, whether by cash, check or charge account.

(To be continued)

Hemagglutination Test in Arthritis

The May issue of the CONNECTICUT STATE MEDICAL JOURNAL included a paper on a modification of the hemagglutination test in rheumatoid arthritis (Boisvert, Hilburg and deForest). The method has been shown to be of considerable aid in the diagnosis of rheumatoid arthritis.

Physicians may use this diagnostic test in their practice by sending one millimeter or more of blood serum in a sterile container to the Streptococcus Laboratory, Grace-New Haven Hospital, 789 Howard Avenue, New Haven. The charge is \$5.

SPECIAL NOTICES

HARTFORD MEDICAL SOCIETY GUEST SPEAKERS

FALL LECTURE SERIES 1955-1956

1955

October 3

Mark D. Altschule, M.D., McLean Hospital, Waverly,
Massachusetts

Metabolic considerations in mental disorders

October 17

Stewart Wolf, M.D., University of Oklahoma, Oklahoma
City, Oklahoma

Evaluation of therapy in disease

November 7

William Dameshek, M.D., New England Center Hospital,
Boston, Massachusetts

Immunohematology in clinical practice

November 21

George Pack, M.D., New York City

The diagnosis and treatment of tumors of the soft
somatic tissues

December 5

Louis Weinstein, M.D., Massachusetts Memorial Hospital,
Boston, Massachusetts

Poliomyelitis—1955

1956

January 16

Richard Warren, M.D., Boston

Thomas Machella, M.D., Philadelphia

Benjamin White, M.D., Hartford (moderator)

Panel: Medical and surgical aspects of the peptic
ulcer

Lectures are presented at 8:30 in the evening at the Hunt
Memorial, 38 Prospect Street, Hartford, Connecticut.

All physicians are cordially invited to attend the address.

NEW ENGLAND CARDIOVASCULAR SOCIETY

November 14, 1955, 8:00 P. M. Morse Auditorium, Museum
of Science, Boston, Massachusetts.

NEW HAVEN HEART ASSOCIATION SPONSORS CARDIACS-IN-INDUSTRY CONFERENCE

As part of its Cardiatics-in-Industry program, the New
Haven Heart Association is sponsoring a conference on
Wednesday, November 16, from 2:00 to 4:30 P. M., in the
Children's Center, 1400 Whitney Avenue, Hamden.

The "Employment of the Cardiac Patient" will be dis-
cussed by outstanding representatives of management, re-
habilitation agencies, industrial physicians and nurses,
cardiologists and practicing general physicians.

Scheduled as speakers are:

Dr. Lewis H. Bronstein of New York, whose topic "The
Employment of Individuals with Heart Disease" will in-
clude records on the effectiveness of cardiacs when given
proper job placement. Dr. Bronstein is director of Work
Classification Unit, Bellevue and Beekman Downtown
Hospitals; associate director of Medical Service, Beekman;
and associate attending physician (Rehabilitation) of Gold-
water Memorial Hospital.

Louis Sachs, Workmen's Compensation Commissioner for
the 3rd Congressional District of Connecticut, who will
talk on the Workmen's Compensation Law.

Norman L. Markel, personnel director of the Gray Man-
ufacturing Company of Hartford, discussing "Management's
Problems in Relation to the Cardiac Worker."

Dr. Robert W. Butler of the Scovil Manufacturing Com-
pany of Waterbury; Dr. David Fogel of Stamford and Miss
Marie Louise Brown, assistant professor of Public Health
(Occupational Health Nursing) in the Yale University
School of Medicine will be additional panel members.

Acting as moderators for the session will be Dr. John
M. Gallivan, chief supervisor of Health and Safety for
United Aircraft, East Hartford; and Dr. Frieda Gray,
assistant professor of Clinical Medicine, Yale University
School of Medicine and superintendent and chief of Medi-
cine, Woodruff Center.

This program, which was planned by members of the
New Haven Heart Association's Education Committee in-
cluding Dr. Herbert S. Harned, Jr.; Miss Doris Gillespie
and Dr. Frieda Gray, is open to all interested.

8th NATIONAL MEDICAL PUBLIC RELATIONS CONFERENCE

Statler Hotel, Boston, Monday, November 28, 1955 (just
prior to opening of AMA Clinical Session).

THE AMERICAN GERIATRICS SOCIETY

In keeping with the objectives of the Society to make
readily available to the medical profession knowledge of
the latest clinical practices having to do with this broad field
The American Geriatrics Society will give a Graduate
Symposium on Geriatric Medicine at the Hotel Roosevelt,
New York City, November 30 and December 1, 1955.

This is a service provided by the Society for its Fellows
and all members of the medical profession.

Distinguished specialists from our leading medical schools
and teaching hospitals will conduct the symposium.

All interested physicians are cordially invited to attend this important symposium.

There will be no registration fee.

CONNECTICUT PUBLIC HEALTH ASSOCIATION SEMI-ANNUAL MEETING DECEMBER 7

William H. Upson, president of the Connecticut Public Health Association, has announced that the semi-annual meeting of the group will be held on December 7, 1955 in the auditorium of the Veterans Home and Hospital, Rocky Hill.

Topics to be discussed are Community Coordination of Health Education; Modern Concepts of Public Health Law and Public Health Aspects of the Recent Flood Emergency.

Louis Speker, M.D., director of the bureau of maternal and child hygiene, Connecticut State Department of Health is chairman of the program committee for this meeting.

ECONOMICS OF MEDICAL PRACTICE

BRADY AUDITORIUM

310 Cedar Street, New Haven, Conn.

Presented by Connecticut State Medical Society, Yale University Department of Public Health, School of Medicine. Thursdays 4:00 P. M. Commencing December 8, 1955.

This course comprises nine lecture and discussion classes on the economics of modern medical care and relationships encountered in the practice of medicine. The course is open to medical students, graduate students, law students, interns and residents, and physicians.

December 8—Medical organization in the United States: its function and objectives. Ernest B. Howard, M.D., assistant secretary of the American Medical Association, Chicago

December 15—Entering practice—choosing a location, placement services, State and local medical societies, professional amenities, announcements, insurance. Creighton Barker, M.D., executive secretary Connecticut State Medical Society, secretary Connecticut Medical Examining Board, New Haven

January 5—State license and specialty boards. 1. The State license, Louis P. Hastings, M.D., member Connecticut Medical Examining Board, pathologist, St. Francis Hospital, Hartford. 2. National Board of Medical Examiners, John P. Hubbard, M.D., executive secretary, NBME, Philadelphia. 3. Specialty boards, Courtney C. Bishop, M.D., associate clinical professor of surgery, Yale Medical School, New Haven. Moderator, Creighton Barker, M.D.

January 12—Physician-patient relationships. Theodore S. Evans, M.D., clinical professor of medicine, Yale Medical School, New Haven. What the physician has a right to expect from the patient—What the patient has a right to expect from the physician

January 19—Third party relationships. The impact of insurance and welfare plans on medical practice. 1. The admin-

istration, William H. Horton, M.D., executive director Connecticut Medical Service, formerly medical director State Department of Public Welfare, New Haven. 2. The practice, Thomas J. Danaher, M.D., chairman Professional Policy Committee of CMS, attending surgeon, Charlotte Hungerford Hospital, Torrington

January 26—Careers in medicine. Surgery, William H. Curley, Jr., M.D., attending surgeon, St. Vincent's Hospital, Bridgeport. Internal medicine, C. Louis Fincke, M.D., attending physician, Stamford Hospital, Stamford. Obstetrics-gynecology, Carl E. Johnson, M.D., associate clinical professor of Obstetrics-Gynecology, Yale Medical School, New Haven. Moderator, John C. Leonard, M.D., director of education, Hartford Hospital, Hartford

February 2—Careers in medicine. Pediatrics, Oliver L. Stringfield, M.D., president Connecticut State Medical Society, attending pediatrician, Stamford Hospital, Stamford. General practice, William H. Upson, M.D., Suffield. Psychiatry, William B. Terhune, M.D., director Silver Hill Foundation, New Canaan. Moderator, William J. Lahey, M.D., director of education, St. Francis Hospital, Hartford

February 9—Careers in medicine. Public health administration, Alfred L. Burgdorf, M.D., director of health, City of Hartford. Hospital administration, T. Stewart Hamilton, M.D., director Hartford Hospital, Hartford. Laboratory practice and research, Paul D. Rosahn, M.D., pathologist, New Britain General Hospital, New Britain. Moderator, Wilson G. Smilie, M.D., professor of Public Health and Preventive Medicine, retired, Cornell University Medical College

February 16—The physician in court. Allyn L. Brown, Esq., past-president Connecticut Bar Association, chairman Conference Committee Connecticut State Medical Society—Connecticut Bar Association, Norwich

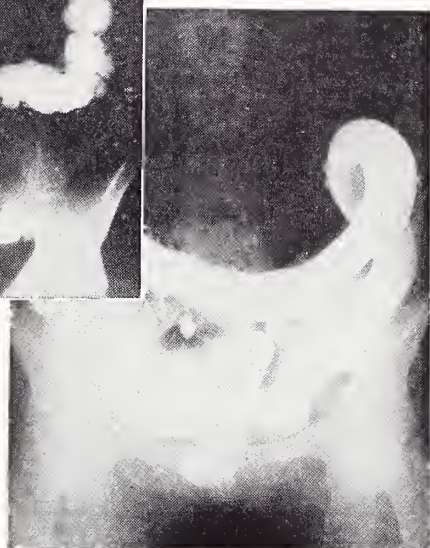
MEDICAL EXECUTIVES' CONFERENCE IN FEBRUARY

The first annual Medical Society Executives' Conference has been set for February 6-7-8 in Chicago's Drake Hotel, and Program Chairman Harvey T. Sethman of Denver said: "it will serve as a teaching course for the new medical executives and as a postgraduate course for the older ones."

A registration fee of \$10 will be charged, and plans call for an exhibit by office equipment manufacturers which is being handled by Bob Lyon of the AMA advertising department.

A tentative program has been drafted. It covers a variety of subjects not normally handled at public relations meetings sponsored by either the AMA or any of the state societies. These include such subjects as the medical society executive and his job, the general organization and structure of organized medicine, the specialty boards, the allied professions, committee organization and procedure, bulletins, publications, and other media, uses of discussion method in association work, letter writing, effective speaking, parliamentary procedure, the legal activities of medical associations, mechanics of association management, financing and

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To initiate the normal defecation reflex, the "smoothage" and bulk of Metamucil provide the needed gentle rectal distention.

Once the habit of constipation has been established, due to any of a large number of causes, it becomes a major problem. Self-medication with irritant or chemical laxatives, or repeated enemas, usually causes a decreased, sluggish defecation reflex and may result in its complete loss.

Rectal distention is a vital factor in initiating the normal defecation reflex, and sufficient bulk is thus of obvious importance in restoring this reflex. Metamucil provides this bulk in the form of a smooth, nonirritating, soft, hydrophilic colloid which gently distends the rectum and initiates the desire to evacuate. Metamucil demands extra fluid, imparting even greater smoothage to the intestinal contents.

It is indicated in chronic constipation of various types—including distal colon stasis of the

"irritable colon" syndrome, the atonic colon following abdominal operations, repressions of defecation after anorectal surgery and in special conditions such as the management of a permanent ileostomy. Metamucil is the highly refined muciloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is supplied in containers of 4, 8 and 16 ounces. G. D. Searle & Co., Research in the Service of Medicine.

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budgeting association activities, investments, membership problems, and a study of personal qualifications and how to improve them.

Experts in each of the respective fields will be asked to serve, and at the end of each session there will be a question and answer period.

QUALIFICATIONS FOR APPOINTMENT TO THE NEW ENGLAND HOSPITAL

All applicants, except those from Canada, England, Scotland and Ireland must have completed one year's internship in their own country before coming for the first time to this country.

She must have a basic working knowledge of English as judged by an Anglo-Saxon through personal interview.

She must submit her medical school curriculum and her application to the New England Hospital before January 1 of each year for appointment on July 1 of the same year. In the interim, between appointment and arrival at the hospital, it is mandatory that she pursue intensively the study of the English language.

She must, if coming directly from a foreign country, attend a course in Hospital Orientation and English instruction for one month in this hospital immediately preceding her 12 month rotating internship.

She must serve a minimum of 12 months in this hospital.

Women physicians wishing to obtain scholarships for travel expense must submit such requests at the time they make formal application for appointment. Such requests must be formally recommended by one of the many recognized international organizations.

OBLIGATIONS ON THE PART OF THE NEW ENGLAND HOSPITAL REGARDING APPOINTMENT OF HOUSE OFFICERS TO THE HOSPITAL STAFF

The New England Hospital agrees to make definitive appointments to the House Staff by January 1 of each year and agrees to notify each applicant of its decision at that time.

The hospital agrees to accept both male and female interns.

EDUCATIONAL OBLIGATIONS OF THE NEW ENGLAND HOSPITAL

The hospital agrees to give to all foreign House Officers coming to the United States for the first time a concentrated course in the English language. This course will begin June 1 of each year, will comprise daily classes, and will be given by an instructor chosen for her qualifications to teach English.

The Active Staff of the hospital will also give a four-week course in Hospital Orientation each year, to acquaint foreign House Officers with our hospital policies and medical procedures. This course will consist of discussions which will be held in conjunction with the English instructor, and demonstrations of such procedures as intravenous therapy, emergency room techniques, oxygen therapy, etc.

Each year the Committee on Education will provide a series of 36 formal lectures during the nine-month period from September 15 to June 15. These lectures are designed to provide instruction in the basic sciences and in the current clinical application of recent advances in the field of therapy. Speakers will be selected from the large group of well known internists, investigators and surgeons who are active in this area.

Four field trips a year to outstanding medical centers in this area will be arranged.

Educational activities within the departments of the hospital comprise the following: Daily ward rounds, daily OPD clinics, weekly clinical conferences and grand rounds, monthly clinical pathological conferences.

Educational house staff activities include: Weekly Journal Club meeting, monthly House Officer's Club meeting.

The Committee on Education and the House Officers agree to submit a yearly report to the referring international organization concerning the over-all accomplishments and mutual benefits derived from the year's activities.

1956 PRIZE ESSAY CONTEST

The Council on Undergraduate Medical Education of the American College of Chest Physicians offers three cash awards to be given annually for the best contributions prepared by undergraduate medical students on any phase in the diagnosis and treatment of chest diseases (heart and/or lungs).

The first prize will consist of a cash award of \$250; second prize will be \$100; and third prize \$50; each winner will also receive a certificate of merit.

The winning contributions will be selected by a committee of chest specialists and will be announced at the 22nd Annual Meeting of the American College of Chest Physicians to be held in Chicago, Illinois, June 7-10, 1956. All manuscripts become the property of the American College of Chest Physicians.

Applicants are requested to study the format of Diseases of the Chest, the official journal of the College, as to length, form, and arrangement of illustrations to guide them in the preparation of the manuscript. A copy of the College journal will be sent upon request. The following conditions must be observed:

1. The completion of an application form, which may be obtained by writing to the executive director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois, U. S. A.
2. Five copies of the manuscript typewritten in English (double spaced) should be submitted to the College offices in Chicago not later than April 10, 1956.
3. The only means of identification of the author shall be a motto or other device on the title page and a sealed envelope bearing the same motto on the outside, enclosing the name and address of the author.

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NEWS

from County Associations

Fairfield

Daniel T. Banks of Bridgeport became a Fellow of the International College of Surgeons at its 20th Annual Congress held recently in Philadelphia.

As president of the Academy of Psychosomatic Medicine William Kaufman of Bridgeport delivered the opening address at the second annual meeting of the Academy recently in New York City. His subject was "Drugs and Mind."

Norwalk Hospital's research program on the causes of rheumatic diseases was given additional support recently with the announcement that the hospital had received a \$10,500 grant from the U. S. Department of Health, Education and Welfare Public Health Service. This is the third grant made to Norwalk Hospital and brings to more than \$19,000 the amount received in recent months for clinical research purposes. Two other grants of \$4,500 and \$4,300 were received earlier this year from the Gustavas and Louise Pfeiffer Research Foundation and the Helen Hay Whitney Foundation.

Hartford

Two Hartford physicians will participate in the course on gerontology offered by Hillyer College and entitled "Counseling the Older Employee." On November 22 H. Gildersleeve Jarvis, president of the Senior League of Hartford, will preside as chairman at a panel discussion on "Counseling for Health and Rehabilitation," and on December 6 T. Stewart Hamilton, director of the Hartford Hospital, will participate in a panel discussion on "Present Developments and Changing Techniques in Counseling." The course started October 4 and convenes Tuesday afternoons through January 24, 1956.

J. E. Rosenfeld has accepted appointment as clinical director of the Commission's Blue Hills Hospital in Hartford. In his position he will direct the hospital's treatment and rehabilitation program and be responsible for the training and supervision of the therapy staff. Dr. Rosenfeld assumes his new position after serving for the past eighteen months on the Commission's staff as psychiatrist in charge

of the Hartford outpatient clinic. He undertakes his hospital duties with a broad background of training and experience and with established reputation in the treatment of emotional illnesses and alcoholism. He is a graduate of the University of West Virginia and received his degree in medicine from the University of Vienna in 1938 which was followed by training in psychiatry at the New York Psychiatric Institute. During World War II Dr. Rosenfeld served with the U. S. Army Medical Corps. Prior to joining the Commission's staff he held positions as senior and later supervising psychiatrist at the Wassaic (New York) State School, and as supervising psychiatrist in charge of the Reception Service at the New York State Harlem Valley Hospital. During this latter period Dr. Rosenfeld was a member of the psychiatric staff at the Child Guidance Clinic in Carmel, New York.

Roger H. Dennett has been named to the post vacated by Dr. Rosenfeld. As psychiatrist-in-charge of the Hartford outpatient clinic of the Blue Hills Hospital Dr. Dennett will supervise all activities of the clinic.

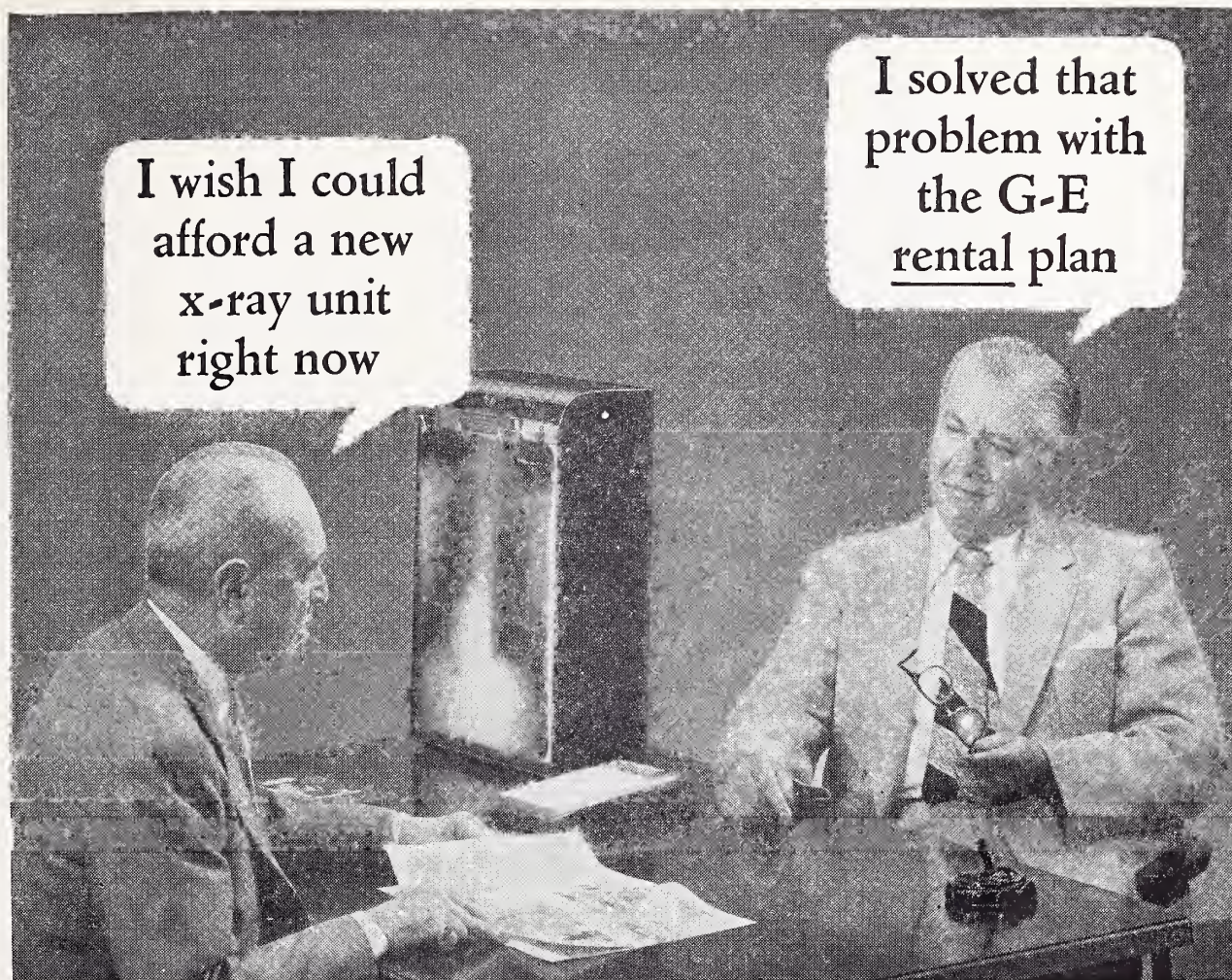
Litchfield

The 191st Semi-annual Meeting of the Litchfield County Medical Association was held at the Torrington Country Club, Goshen, on October 4. The meeting, preceded by a social hour and an excellent steak dinner, was conducted by Richard I. Barstow of Norfolk, president.

Present at the meeting were Oliver L. Stringfield, president of the State Medical Society; Creighton Barker, executive secretary of the State Society; Stanley Osborn, commissioner of the State Department of Health; William Horton, director of the Connecticut Medical Service; Victor G. H. Wallace, director of the Connecticut Regional Blood Program operated by the Red Cross, and visiting delegates. All these guests gave enlightening information of their activities, statewide.

Absent this time was the perennial delegate of Fairfield County, James D. Gold, who is at present a patient in the Bridgeport Hospital. It was voted by the society that he be sent greetings in the form of a telegram and a bottle of bourbon.

Two new members were elected to the Association: Freeman Fletcher Brown of Torrington, a transfer from Hartford County, and Frank Edward Smith, Jr. of Lakeville, a transfer from the County Society of New York.



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always up to date . . . without "trade-ins."

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For the vacancies existing in the Professional Policy Committee of the Connecticut Medical Service, Inc., the following men were elected: A. Rocke Robertson of Torrington, Obstetrics and Gynecology; Gaert S. Gudernatch of Sharon General Practice; Camille H. Huvelle of Litchfield, Internal Medicine.

The speaker of the evening was Mr. Ralph L. Towne of Litchfield, an astute sales manager of a prominent industrial concern. His topic, "The Human Side of Selling," was as applicable to the physician as it was to the layman. An accomplished, finished after-dinner speaker, Mr. Towne discussed his present day methods in selling himself and his company's products. His humorous illustrations and witty comments had the men literally "rolling in the aisles," and it was with regret that his talk ended all too soon.

Middlesex

John Korab attended the annual meeting of the American Heart Association in New Orleans the latter part of October.

New Haven

Albert W. Snoke, director of Grace-New Haven Community Hospital, was chosen president elect of the American Hospital Association at its recent annual convention in Atlantic City.

Robert S. Gordon of Woodbridge has been appointed medical director of the Security-Connecticut Life Insurance Company. Dr. Gordon will continue in the private practice of internal medicine in New Haven.

Burton L. Tolles of Ansonia, where he had practised medicine for 47 years, died in the Griffin Hospital on September 21.

Clayton B. Mather, director of public health in Waterbury for two years, resigned as of November 12 to accept a new position in Ohio.

Nicholas M. Greene joined the faculty of Yale University School of Medicine on July 1, 1955, as professor of anesthesiology and lecturer in pharmacology. He will be director of anesthesiology in the Grace-New Haven Community Hospital. Dr. Greene will develop an expanded teaching and investigative program in anesthesiology at Yale. To assist him in his program he has brought with him from Rochester Dr. Alastair J. Gillies who has been appointed assistant professor of anesthesiology

and associate director of anesthesia at the Grace-New Haven Community Hospital. Dr. Gillies' father is the professor of anesthesia at Edinburgh University.

New London

John E. Morrison, a member of the staff of the Norwich State Hospital, has been appointed clinical director in charge of the medical and surgical services. He has been directly in charge of the Medical Surgical Building since his hospital appointment in June, 1950. Now he will assume in addition responsibility for the tuberculosis service and will direct the operations of the intrahospital clinics for patients and employees.

Alfred Labensky attended the World Medical Association sessions in Vienna in September as an official observer of the United States Committee.

The 165th Semi-annual Meeting of the New London County Medical Association was held at the Mohican Hotel, New London, on Thursday October 6. At the business meeting the following new members were elected: John Caruso, Jr. of New London, graduate of the Boston University School of Medicine class of 1949, Thomas Joseph Master-son of Norwich, graduate of the Tufts College Medical School, 1945. Business meeting was followed by a dinner at 7:30, and a scientific session at 8:30. The main speaker was Arthur Thibodeau, orthopedic surgeon at the New England Medical Center, who spoke on the "Management of Common Bone Disorders."

On September 27 the St. Lukes Physicians Guild had their monthly meeting at the conference room of the Lawrence Memorial Hospital. After a business meeting the speaker was Rev. Joseph Leo Flynn, C.P., who spoke on "The Power of Daily Reflection." The regular monthly meeting of the staff of the William W. Backus Hospital was held on Thursday evening, October 13. Dr. Warren Kerr of the Massachusetts General Hospital spoke on "The Treatment of Urinary Infections."

The New London Chapter of the Connecticut Heart Association invited all doctors to attend the monthly cardiovascular lecture on Thursday, October 13, at the Lawrence and Memorial Hospital. J. Scott Butterworth, associate professor of medicine at the New York University Post Graduate Medical School, spoke on "Auscultation of the Heart." The New London Chapter of the Connecticut Heart Association will have a monthly lecture

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from now until May, which will come on the second Thursday of the month. Joseph Wool is in charge of the program.

Windham

DAY-KIMBALL HOSPITAL IN THE FLOOD

On August 19 when the flood hit Putnam by mid afternoon the Day-Kimball Hospital was without electricity except for its own small auxiliary generator, without water and without telephone service. That night, through cooperation of the Civilian Defense, a generator was brought down from its storage in Pomfret and placed outside the hospital and connected up. This produced enough auxiliary electricity to allow the use of all of the lights instead of just the ones that the small auxiliary made possible, and the use of the elevator or one x-ray machine, but not both at the same time. The little pond behind the hospital was used for water to flush toilets. Extra pails were bought in Pomfret and each floor of the hospital had five or six pails of water in the corridor and when a toilet had to be flushed a nurse or anyone involved would take a pail along to the toilet. The drinking water was, of course, a tremendous problem and this was solved by one of the doctors picking up a truck from a milk man in Pomfret, borrowing along with the truck many milk cans, and going to Pomfret and filling the cans with drinking water. These were brought back to the hospital where they were very welcome.

Without interns or residents, doctors could not be called by telephoning because of the lack of telephones and so the staff met in an emergency meeting and twelve men volunteered to spend six hours each every three days at the hospital in succession. This made four shifts, 6:00 A. M. to 12:00 noon, 12:00 noon to 6:00 P. M. and 6:00 P. M. to 12:00 midnight and 12:00 midnight to 6:00 A. M. This worked out very well, the men were glad to do it and some doctor was available all the time for a whole week.

Physicians on the east side of the Quinebaug River, in order to reach the hospital a distance of about a half a mile, at times had to go to Danielson and cross the Brooklyn bridge into Brooklyn, a matter of twenty-four miles. One day, when this bridge was not usable, they had to go almost into Jewett City to cross the Quinebaug and this made a trip of 44 miles.

As far as is known, only one major operation was transferred to another hospital and within four or five days practically all of the services were back in functioning order.

* * * *

Sidney Vernon of Willimantic is the author of "Massive Prolapse of the Rectum: Report of a Case" published in the *Journal of the International College of Surgeons*, August, 1955.

Children's Tumor Clinic at Yale

A children's tumor clinic, the first of its kind in Connecticut, has been established at the Yale-New Haven Medical Center. The clinic is sponsored jointly by the Yale School of Medicine, the Grace-New Haven Community Hospital, and the Connecticut Division of the American Cancer Society. It will be directed by Dr. David H. Clement, associate clinical professor of pediatrics, and Dr. Alan Merman, clinical instructor in pediatrics.

The new clinic is designed to work with the referring family physician on a consultation basis. It will supplement diagnostic facilities and make available all services of the medical center. The clinic staff will devote their attention chiefly to the investigation and management of benign and malignant neoplastic diseases of children. Emphasis will be placed on early detection of suspected tumors.

FISKE FUND PRIZE DISSERTATION

The Trustees of what is considered America's oldest medical essay competition, the Caleb Fiske Prize of the Rhode Island Medical Society, announce as the subject for this year's dissertation "Use of Radio-active Isotopes in the Treatment and Investigation of Disease." The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of \$350 is offered.

For complete information regarding the regulations write to the secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

AMA FILMS AVAILABLE

A revised list of films available through the AMA motion picture library has been prepared and copies are available upon request from the Committee on Motion Pictures and Medical Television of the American Medical Association. This catalog lists 83 medical films suitable for showing to medical societies, hospital staff meetings and other scientific groups. The catalog also includes 36 health films of interest to physicians who may be called upon to speak before lay audiences such as service organizations, Parent-Teachers' Associations, etc.



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NEW BOOKS IN REVIEW

COLLECTED PAPERS OF THE MAYO CLINIC AND THE MAYO FOUNDATION. Vol. XLVI, 1954. Edited by Richard M. Hewitt, B.A., M.A., M.D., et al. Philadelphia: W. B. Saunders Company. 1955. 843 pp.

Reviewed by HENRY M. WILLIAMS

This volume is a collection of papers received by the Section of Publications, Mayo Clinic and Mayo Foundation, Rochester, Minnesota, during the year 1954. Most of the papers have been published in various journals, and many appear in this volume in abridged form or as an abstract. About half of the one hundred and thirty-four articles appear in full.

The book is divided into sections as follows: Alimentary Tract, Genitourinary Diseases, Ductless Glands, Blood and Circulatory Organs, Dermatology, Head, Trunk and Extremities, Thorax, Brain, Spinal Cord and Nerves, Radiology, Physical Medicine and Rehabilitation, Anesthesia and Miscellaneous.

It would be impossible to mention all the articles presented, but a few of the topics that are treated most adequately may be cited. Particularly noteworthy is a series of papers dealing with both the medical and surgical aspects

of duodenal and gastric ulcer. Also there is an excellent summary of experience in the management of chronic ulcerative colitis; a conservative approach to this disease is advocated, with reliance on general supportive measures and salicylazosulfapyridine (azulfidine). Steroid therapy is reserved for the management of complications such as arthritis, pyoderma gangraenosa, uveitis and intractable anorexia. Likewise surgery tends to be limited to those patients who show polyposis, carcinoma, fistulas or perforation.

Other conditions that are discussed admirably include chronic nephritis, hyperthyroidism, pheochromocytoma and trigeminal neuralgia. With regard to the latter, the role of injection therapy, differential posterior sensory root section, and decompression of the gasserian ganglion are considered. Particularly rewarding is a paper discussing various neurosurgical conditions that masquerade as general surgical problems, such as brain or spinal cord tumors presenting as surgical disease of the abdomen. Also of note is an excellent discussion of the neurologic complications of diabetes mellitus; incidentally, these authors feel that the ocular palsies seen in diabetes are not due to metabolic factors but probably represent tiny vascular lesions of the brain stem.

Although the material presented offers something of interest to almost every medical and surgical background, as a collection these papers are more suitable for library usage rather than individual ownership. Certainly the volume represents a valuable commentary on the current thinking and practices of the Mayo Clinic and Foundation, as well as providing a review of their substantial experience in many aspects of medicine and surgery.

THE TECHNIQUE OF PSYCHOANALYSIS. By Edward Glover. New York: International Universities Press. 1955. 404 pp. \$7.50.

Reviewed by RICHARD KARPE

Since Fenichel's *Problems of Psychoanalytic Technique* no complete discussion of technical problems of the psychoanalytic procedure has been published. The field remained filled with the exposition of modifications or popular simplifications. Glover's book is not meant for the general reader including the psychiatrist even if he is psychoanalytically oriented, but for the small group of practicing psychoanalysts, who are called "orthodox" or "Freudians," who adhere to Freud's method of investigating the unconscious by listening to "free" associations and interpreting them, who attempt the recovery of patients by insight rather than by persuasion, relationship, or other forms of management. For the student, teacher, or practitioner of classical psychoanalysis it is a very valuable book.

More than one-half of the book is a scientific discussion of technical problems, such as the opening phase, defense-resistance, counter-resistance, and counter-transference, transference, the terminal phase, and activities during treatment as a more detailed description of accessible, moderately accessible, and intractable cases. The second part is the result of a questionnaire which was sent twenty years ago to twenty-nine psychoanalysts and answered by twenty-four of them. The third part contains three independent papers related to the topic of the book. They are: "The Therapeutic Criteria of Psychoanalysis," "The Therapeutic Effect of Inexact Interpretation," and "On the Theory of the Therapeutic Results of Psychoanalysis." This book is not

recommended for the untrained or unqualified reader but is recommended as a textbook in the training of psychoanalysts.

ION EXCHANGE AND ABSORPTION AGENTS IN MEDICINE (*The Concept of Intestinal Bionomics*). By *Gustav J. Martin, sc.D.*, Research Director, The National Drug Company, Philadelphia. *Boston, Toronto: Little, Brown and Company.* 1955. 333 pp. \$7.50.

Reviewed by **DESMOND D. BONNYCASTLE**

The concept of ion exchange and chemistry of anion and cation exchange resins are considered initially. The application of these materials to clinical problems constitutes over half of the book. A great deal of evidence is brought forward to support the use of anion exchange resins in peptic ulcer therapy, and the use of cation exchange resins in the treatment of congestive heart disease. Among the other proposed suggestions for the use of these resins has been, for example, in the case of the anion resins, the treatment of heartburn in pregnancy where they have been found to be as effective as prostigmine; and in the case of the cation resins, such disease entities as cirrhosis of the liver, hypertension and the nephrotic syndrome have been said to be benefited by their use. Evidence is presented to show clearly that a mixture of exchange and absorbent materials is much more effective in counteracting effects of toxic substances in the gastrointestinal tract than the standard absorbent type of therapy. For completeness, a brief description and discussion of various nonresinous exchange and absorption materials such as charcoal, kaolin, magnesium trisilicate, aluminum hydroxide, Bentonite is presented as well as a consideration of a number of chelating compounds. In the final chapter the concept of intestinal bionomics is developed, for which very meager scientific evidence is presented. The value of this book lies in its factual information.

A TEXTBOOK OF PHYSIOLOGY. Seventeenth Edition. Edited by *John F. Fulton, M.D.*, Sterling Professor of the History of Medicine, Yale University School of Medicine; with the collaboration of: *Donald H. Barron; William D. Blake; John R. Brobeck; George R. Cowgill; Paul F. Fenton; Thomas R. Forbes; Samuel Gelfan; David I. Hitchcock; Hebbel E. Hoff; David P. C. Lloyd; Theodore C. Ruch; Jane A. Russell.* Philadelphia and London: *W. B. Saunders Company.* 1955. 1,275 pp. 600 illustrations. \$13.50.

Reviewed by **DESMOND D. BONNYCASTLE**

It is always pleasant to welcome another edition of Fulton's textbook of physiology. Many of the authors are ones with whom we are already familiar in past editions, although here and there a new name appears. This textbook has always been celebrated for its treatment of neurophysiological matters and in fact almost half of the book is devoted to this field. A fairly common fault in collaborative works of this type is that they give the impression of a series of monographs rather than an integrated whole, and occasionally one is aware of unevenness. Nevertheless, in spite of this fault, this is a book which can be commended for its wealth of authoritative information, particularly in those fields for which it is best known. It may be that the general reader will find this somewhat cumbersome and too specialized a book, however, he may be assured of its value and usefulness.

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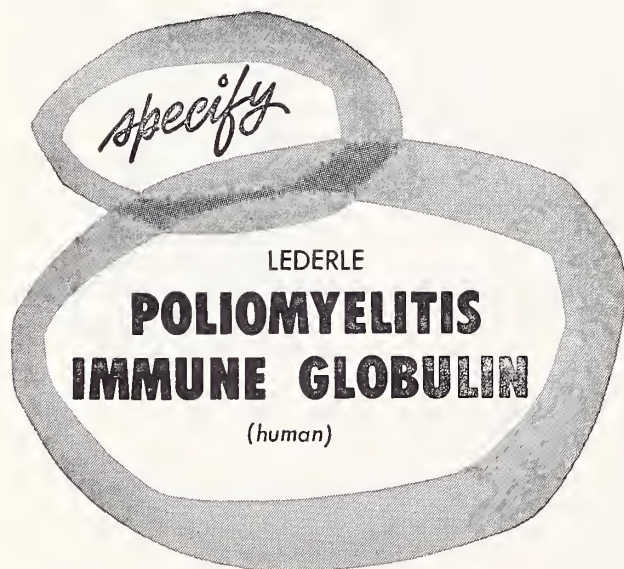
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CHRISTOPHER'S MINOR SURGERY. Seventh Edition.

Edited by Alton Ochsner, M.D., F.A.C.S., William Henderson Professor of Surgery and Chairman of the Department of Surgery, Tulane University of Louisiana School of Medicine, and Michael E. DeBakey, M.D., F.A.C.S., Professor of Surgery and Chairman Department of Surgery, Baylor University School of Medicine, Houston, Texas. Philadelphia: W. B. Saunders Company. 1955. \$9.

Reviewed by P. J. COSTA

This seventh edition of Christopher's Minor Surgery is a completely new book. Not only is the text changed from the previous editions but also the format, style of writing, and chapter headings. The book expresses primarily the viewpoints of three schools: Louisiana State, Tulane and Baylor, and for this reason may be somewhat narrow in scope. It is, however, a concise, clear informative presentation of all phases of minor surgery, both elective and emergency. The chapters are primarily on a systemic basis (Skin and Subcutaneous Tissues; Musculo-Skeletal; Alimentary; Peripheral Vascular; Genitourinary; Head and Nervous System) which facilitates its use as a book of reference. The introductory chapter on "General Considerations" takes up such topics as "anesthesia and resuscitation" and the "surgical resident" which help to make this text an excellent introduction for both medical students and housestaff. The illustrations and photographs are clear and very well explained. The bibliography is on an individual chapter basis. Although this text presents a selective point of view it may be well recommended to the medical student, housestaff and practitioner.

REACTIONS WITH DRUG THERAPY. By Harry L. Alexander, M.D., Emeritus Professor of Clinical Medicine, Washington School of Medicine; former editor of the Journal of Allergy. Philadelphia and London: W. B. Saunders Company. 1955. 301 pp. 33 illustrations. \$7.50.

Reviewed by DESMOND D. BONNYCASTLE

This informative book considers the reactions in man to drugs, that have been classified as hypersensitive reactions. The term hypersensitive is used to denote an abnormal reaction to the drug exposure, rather than the pharmacological meaning of the word which is that on exposure to a small dose, the response expected from a maximal dose is obtained. The author subscribes to the view that the majority of these hypersensitivity reactions are mediated by an allergic mechanism. The mechanisms involved in sensitization and the various dermatologic and systemic manifestations are considered first in a general manner. Finally, the reactions that have been reported following exposure to various groups of drugs are dealt with. Among the groups of drugs considered might be mentioned: the chemotherapeutic preparations such as the sulfonamides and arsenicals; the antibiotic drugs and the antitubercular substances; the antiarthritic compounds; the sedatives; the cardiovascular drugs; the antithyroid materials; the antihistaminics, and the local anesthetics. This book is a useful and interesting one, and is recommended to all. However, it is unfortunate that the material from which the author had to draw was not more detailed, so that a proper evaluation of the incidence of the various lesions could be made. But this is a minor criticism, and as more facts become available during the next few years it is to be hoped that they may be included in a subsequent edition.



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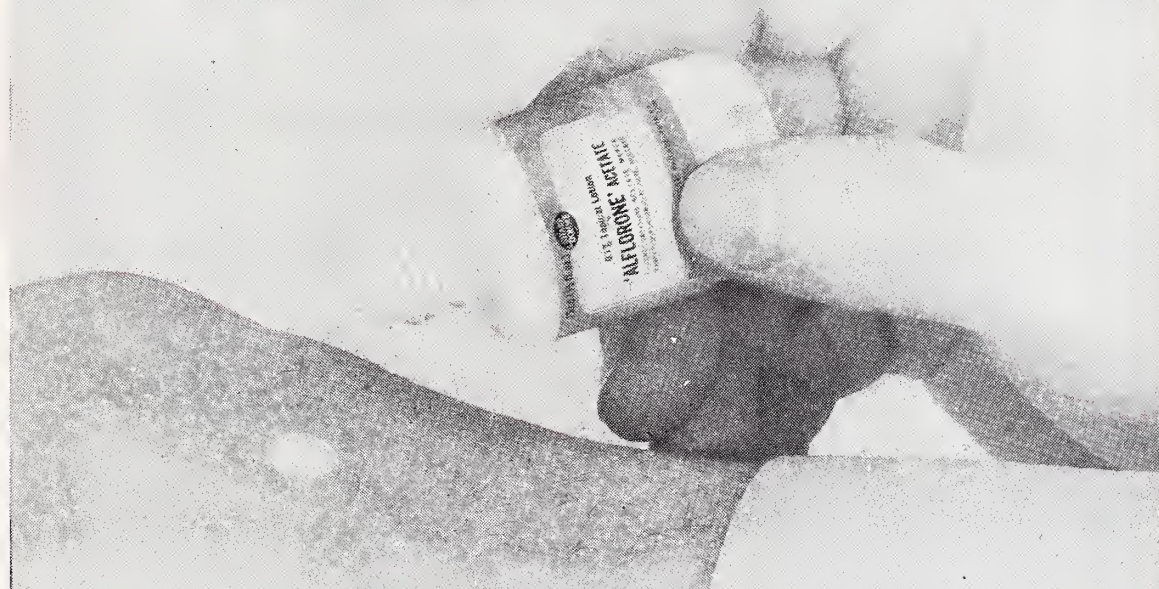
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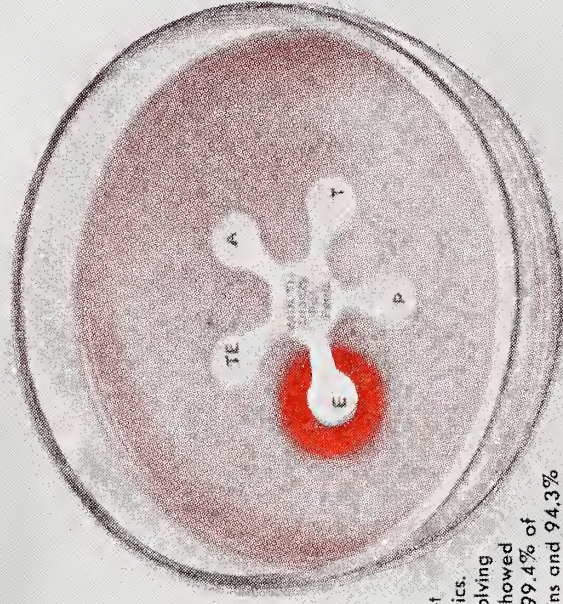
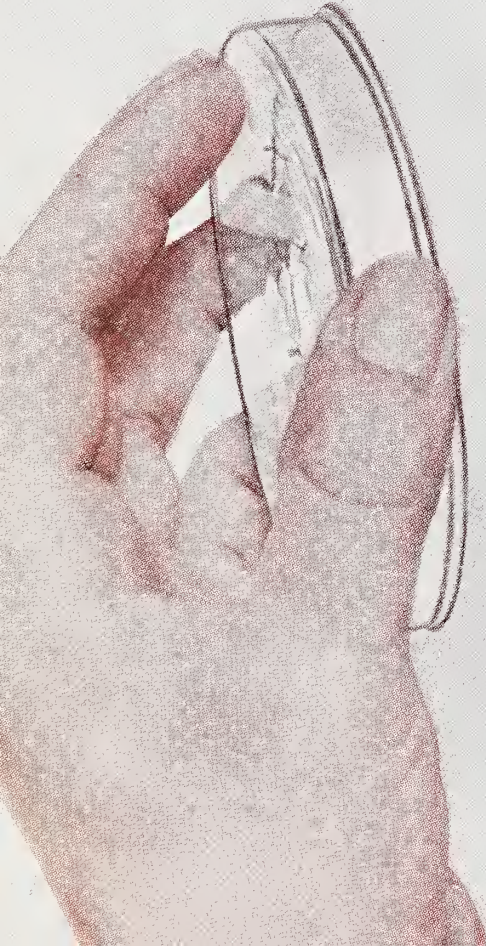
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J. Eisenberg, et al., Antib. & Chemo., 3:1026-1028, Oct., 1953.



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ANTICOAGULANT THERAPY

Its Present Status in Acute Myocardial Infarction

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IN December, 1948 the Committee on Anticoagulants of the American Heart Association, after extensive studies, asserted that anticoagulant therapy should be used in all cases of coronary thrombosis with myocardial infarction unless a definite contraindication exists.¹ Under the impetus of this declaration and the confirmatory independent studies which rapidly appeared in the literature, the administration of anticoagulants quickly became routine practice in the treatment of acute myocardial infarction in the United States and was adopted in various centers throughout the world. Although many physicians remained unconvinced or uncertain regarding the benefits to be derived from this radical form of therapy, in spite of the wide favorable publicity which it received in both medical and lay publications, physicians often continued its routine use chiefly through fear of criticism by colleagues or of reproach by patients or their relatives. In the years 1949 to 1951 relatively few practitioners keeping pace with the progress of medicine would have been courageous enough to admit openly that they had withheld anticoagulants in cases of acute coronary occlusion when no contraindications were present. In fact, some candidly expressed real apprehension at the thought of possible litigation for malpractice if death or complications were to develop in their patients not receiving these drugs.² As a consequence, anticoagulants were often employed in "token" dosage without any sincere attempt to achieve prothrombin times within the

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SUMMARY

It is part of the natural history of discovery to find that enthusiasm and emotion frequently outstrip logic. The introduction of anticoagulants for the treatment of acute myocardial infarction has not proved an exception to this general rule. Early advocates of this therapy recommended routine administration in all cases in which contraindications were absent. For a time physicians feared to deviate from this rigid dictum or to exercise their own clinical judgment because of the consequences which might ensue. With accumulating evidence, however, it is becoming increasingly clear that anticoagulants like other drugs should be used only under certain well defined circumstances. Although anticoagulant therapy appears to be of distinct value in serious cases of acute myocardial infarction, all the evidence to date seems to indicate that there is no basis for its use in patients with an uncomplicated first attack. In the latter, the risk of hemorrhagic complications may be greater than the small risk of thromboembolic episodes when anticoagulants are withheld.

therapeutic range. During that period, however, several groups of investigators, aware of the apparent value of anticoagulants in treatment of severely

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ill patients with acute myocardial infarction, sought to determine whether or not patients with clinically mild episodes also share in the overall benefit shown to be derived from this form of treatment. Although the Committee on Anticoagulants had attempted to supply such data, their study provided no information concerning the fate of patients with an uncomplicated first attack with or without the administration of these agents.

It has been traditional in medical teaching to emphasize that the outcome of acute myocardial infarction is always "unpredictable because of the constant threat of sudden unexpected death even for persons convalescing favorably."³ This prevailing view has long been responsible for a gloomy outlook on the part of the attending physician even in cases presenting a benign clinical picture. Furthermore, although individual consideration of patients and the treatment of each case according to its own merits are prime ingredients of good medical practice, this pessimistic concept of prognosis has resulted in a formalized and stereotyped method of treatment for all cases of coronary occlusion without regard to mildness or severity of the attack. Consequently, when we first undertook to analyze the mortality rate and incidence of thromboembolism in "good risk" cases treated conservatively, we had anticipated finding a significant incidence of thrombotic complications and an unpredictability of prognosis. It was therefore a revelation to find that, contrary to existent views, clinical selection at the onset of the attack or early in its course is capable of identifying patients in whom the outcome could be predicted with a high degree of accuracy.^{4,5} Moreover, in these selected patients the incidence of thromboembolism was found to be so low as to challenge the need for anticoagulant therapy in their management.⁶⁻⁸ Thus, by assessing eight important signs and symptoms, it seemed possible to determine whether or not a patient was a "poor risk" requiring anticoagulant drugs or a "good risk" requiring only the more traditional methods of management. To make this differentiation the following poor prognostic signs were tabulated: (1) a history of previous myocardial infarction, (2) intractable pain, (3) extreme degree or persistence of shock, (4) significant enlargement of the heart, (5) gallop rhythm, (6) congestive heart failure, (7) auricular fibrillation or flutter, ventricular tachycardia, or intraventricular

block, and (8) diabetic acidosis or other states predisposing to thrombosis.

Of a total of 1,047 consecutive admissions for acute myocardial infarction to three New York hospitals, 489 or 47 per cent qualified as "good risk" because of having sustained an uncomplicated first attack as judged from a retrospective analysis of the clinical signs and symptoms listed in their case records on the day of admission to the hospital.⁷ The death rate during the period of hospitalization among these 489 "good risk" patients was found to be only 3.1 per cent and if survival extended beyond the first 2 days of admission the recovery rate was 99 out of 100 (Table I). The death rate in this large segment of cases of coronary occlusion that we have designated "good risk" is therefore less than that commonly recorded for pneumococcal pneumonia under modern antibiotic therapy. Furthermore, analysis of the causes of death in this group indicated that the preventable mortality under ideal anticoagulant therapy could not have exceeded 1 per 100 cases even if all deaths of unknown cause were attributed to thrombotic or thromboembolic episodes. The clinical incidence of such complications in these patients was only 0.8 per cent. Consequently, in this low risk group it seems justified to attempt to weigh the possible benefits from anticoagulant drugs against the risks inherent in their use. The Committee on Anticoagulants, working with teams of research fellows, residents and staff members in many of the leading medical centers in

TABLE I
MORTALITY RATE AND INCIDENCE OF THROMBOEMBOLIC COMPLICATIONS

	NO. OF CASES	MORTALITY		EMBOLIZATION	
		NO.	PER CENT	NO.	PER CENT
Total	1,047	350	33.4	63	6.0
Good risk	489	15	3.1	4	0.8
Poor risk	558	335	60.0	59	10.6

the United States, and assisted by the most reliable laboratory facilities, observed hemorrhagic complications from anticoagulants in 7 per cent of their first series¹ and in 13 per cent of their second;⁹ and the death rates from hemorrhage due to anticoagulants were 0.7 per cent and 1.1 per cent, respectively. After careful consideration of all clinical and necropsy findings Wright recently estimated that 1.7 deaths per 100 cases resulted from anticoagulant

therapy itself.¹⁰ It is true, however, that in “good risk” cases treated with anticoagulants the incidence of hemorrhagic complications may be somewhat less than these figures indicate. With newer anticoagulants and meticulous care some have claimed a negligible incidence of hemorrhagic complications. Nevertheless it must be remembered that as a cause of death hemorrhagic episodes may be even more elusive than thromboembolic phenomena, their presence often being revealed only after careful necropsy study. Deaths from hemorrhage in the brain, gastrointestinal tract and other sites have been reported in cases running a benign clinical course during anticoagulant therapy.² Furthermore, it is of some significance that many observers have been impressed with the frequency of embolic phenomena while the prothrombin time is within good therapeutic range and with the incidence of significant hemorrhage when the patient is apparently under satisfactory control. From the evidence, therefore, it appeared difficult to justify the use of a procedure which, though rarely more than 50 per cent to 60 per cent effective, is associated with a danger approaching that for which its employment has been strongly recommended. The probable results of anticoagulant therapy given by busy practitioners or by specialists in smaller institutions, without the advantages of teamwork, and where laboratory facilities are often over-taxed, inadequate or substandard, must also be considered. One must not lose sight of the fact that the majority of patients with acute myocardial infarction are treated by general practitioners and not by specialists in research hospitals and that many patients are still being treated at home. In a survey made by us in 1953 by means

of a questionnaire, 228 cardiologists and internists reported 122 deaths caused by hemorrhage from anticoagulants given in the treatment of acute myocardial infarction.²

Notwithstanding this evidence, Wright¹¹ and Nichol and associates¹² challenge the validity of data derived from retrospective studies of hospital case records, contending that it is much more difficult to classify patients prognostically at the onset of an attack than in retrospect after their discharge from the hospital. Objection has also been raised against flexibility in therapy relative to our judgment of the severity and anatomy of the attack on the grounds that one cannot always be certain as to what constitutes a small myocardial infarct, and further, that what starts as a mild attack may become severe a few hours later.¹³ The feasibility and justification of such classification at the onset of the attack or early in its course to determine the need for anticoagulant therapy, however, have been clearly demonstrated in a recent study in which we observed the clinical course and outcome in an additional 122 cases classified as “good risk” and treated by conservative measures without anticoagulants.⁸ In this series anticoagulant therapy was intentionally withheld in each instance because of the absence of the poor prognostic signs enumerated above, at the first examination on admission to hospital. The mortality rate for this group was 4.9 per cent, but careful analysis of the causes of death revealed that the preventable mortality under ideal anticoagulant therapy could not have exceeded 0.8 per cent. In the entire series there was not a single instance of cerebral or of peripheral arterial embolism. Clinical thromboembolic phenomena were

TABLE II
MORTALITY AND INCIDENCE OF THROMBOEMBOLISM IN “GOOD RISK” OR “MILD” CASES OF ACUTE MYOCARDIAL INFARCTION

INVESTIGATORS	NO. OF CASES	MORTALITY RATES			THROMBO- EMBOLISM PER CENT
		OVER-ALL PER CENT	AFTER 48 HOUR PER CENT	PREVENT- ABLE PER CENT *	
Russek and others, ^{4,6} 1951-52	489	3.1	1.2	1.0	0.8
Papp and Smith, ¹⁴ 1951	69	0.0	0.0	0.0	0.0
Littmann, ¹⁶ 1952	109	—	1.8	0.9	1.8
Furman and others, ²⁸ 1953	76	—	1.3	—	4.0
Committee on Anticoagulants, ¹⁰ 1953	24	—	0.0	0.0	16.0
Russek and Zohman, ⁸ 1954	122	4.9	2.5	0.8	3.3

*Percentage of deaths theoretically preventable if anticoagulants had been used

observed in only 4 patients, an incidence of 3.3 per cent. In two of these four patients, moreover, the diagnosis of this complication was only presumptive.

Similar observations and conclusions have been recorded in the literature by an increasing number of authors. All studies of selected "good risk" cases of acute coronary occlusion published hitherto, including those of Wright, clearly reveal that the death rate among such patients cannot be significantly altered by anticoagulants^{6-8,11,14-16} (Table II). It is of interest that even of those who participated in the anticoagulant study sponsored by the American Heart Association, a significant number consider that anticoagulant therapy confers no benefit in clinically mild cases of acute myocardial infarction.¹⁷

The wide employment of anticoagulant drugs in acute coronary thrombosis has been associated with another risk, commonly overlooked. In order to institute treatment without delay many patients are rushed to the hospital shortly after the onset of their clinical attack, despite the fact that the highest death rate in this disease prevails during the first forty-eight hours. Since these early deaths are the result of ventricular fibrillation, cardiac asystole, shock or congestive heart failure, and are unrelated to thromboembolism, they almost certainly cannot be prevented by anticoagulant drugs. The desire to save the small proportion who may die from thromboembolism after the first week may therefore jeopardize the chances for survival of the much larger segment of coronary cases known to die from other causes during the first two days. For many patients, being jostled in an ambulance or admitting office, then subjected to the psychic trauma of a hospital room and bed, and of being placed in an oxygen tent, often when oxygen is entirely unnecessary, and being repeatedly punctured for prothrombin and coagulation times hardly constitutes optimum management during this early critical period. In most instances any form of treatment deemed necessary can be initiated in the patient's home and removal to a hospital can be accomplished, if indicated, when this critical period has passed.

It has been repeatedly claimed that old age provides special indication for the use of anticoagulants in acute coronary occlusion. Wright¹⁸ considers that, although the incidence of thromboembolism may be no greater in aged than in young patients, the older patient is more vulnerable and less likely to survive the consequences of thromboembolism. We have shown, however, that no justification exists

for the concept that age is an important factor in determining the prognosis in the individual case.^{19,20} Statistically there is a higher incidence of serious attacks among older patients, with consequently a higher incidence of thromboembolism (Table III).

TABLE III
ANALYSIS OF CASES OF ACUTE MYOCARDIAL INFARCTION
ACCORDING TO AGE AND SEVERITY OF ATTACK

	TOTAL	"GOOD RISK"	"POOR RISK"
All ages	1,047	489 (46.7%)	558 (53.3%)
Under 60 years	618	331 (53.6%)	287 (46.4%)
60 years or over	429	158 (36.8%)	271 (63.2%)

For this reason alone anticoagulants have shown a greater life-saving action in patients aged more than 60 than in younger patients.¹ It has not been recognized, however, that the prognosis for a severe attack or a mild one is uninfluenced by age. Our comparisons of cases of similar severity in different age groups have repeatedly demonstrated similar mortality figures¹⁹⁻²¹ (Table IV). One must therefore conclude that the initial clinical appearance of the patient, irrespective of age, constitutes the best index to his future course and the deciding factor regarding the need for anticoagulants.

TABLE IV
MORTALITY RATE IN CASES OF ACUTE MYOCARDIAL INFARCTION
ACCORDING TO AGE AND SEVERITY OF ATTACK

	TOTAL	"GOOD RISK"	"POOR RISK"
All ages	33.4%	3.1%	60.0%
Under 60	28.8%	3.0%	58.5%
60 or over	40.1%	3.2%	61.6%

It has been suggested that anticoagulants may have additional life-saving actions beside that of preventing thromboembolism. Some have contended that these agents ward off congestive failure, ventricular fibrillation and asystole by preventing further clotting in the coronary lumen. Gilbert and Nalefski²² have attributed the favorable results observed from the use of anticoagulant drugs in cases of acute myocardial infarction and angina pectoris primarily to an increase in coronary blood flow. Graham and associates,²³ on the other hand, in reporting pronounced relief of anginal symptoms in patients receiving periodic injections of heparin, ascribe the beneficial response to the profound effect of the drug on lipoprotein metabolism. Other studies with heparin, however, have failed to demonstrate either subjective improvement in anginal symptoms or

favorable influence on the electrocardiographic response to standard exercise.²⁴ The recent report of Gilchrist²⁵ offers a possible explanation for the unexpectedly large benefits reported from the use of anticoagulant drugs. This author observed that the early and efficient use of heparin and Dicumarol or Tromexan appears to influence favorably the outcome of the shock syndrome. Deaths from the severer grades of shock were reported to have been reduced from 15 to 4 per cent as the result of therapy. Gilchrist suggests that the early employment of heparin in addition to the more slowly acting anticoagulants may limit the spread of multiple thrombotic extensions in and through the zone of demarcation separating the necrotic from the adjoining healthy muscle. Control of the thrombotic tendency may thus prevent an advance in the vicious cycle of thrombosis, infarction and hypotension. If these findings are confirmed, the current practice of administering Dicumarol or Tromexan alone without the immediate use of heparin must be viewed as falling far short of achieving optimum benefits from anticoagulant therapy in many cases.

Of 1,318 patients, 611 (46 per cent) qualified as "good risk."⁸ When the mild cases treated at home by conservative measures and the persons with serious attacks who manifest specific contraindications to anticoagulant therapy are taken into account, probably not more than 30 per cent of all cases can be considered suitable for anticoagulant treatment. This low estimate should not detract, however, from the value of anticoagulants in properly selected cases—i.e., those with poor prognostic signs—since their administration in such cases constitutes a major advance in the treatment of acute myocardial infarction.

Not all physicians share the view that anticoagulant therapy represents a forward step in the management of acute myocardial infarction. Evans²⁶ has stated that: "Anticoagulant therapy has failed to satisfy any of the three demands made by the code set to test its efficiency in coronary occlusion. . . . That anticoagulant therapy in coronary occlusion will go the way of other discarded remedies is certain. . . . Let it go now, before remorse weighs too heavily on those who may continue for a little longer to advocate its use." Evans claims that laboratory control is inadequate to prevent hemorrhage from the use of anticoagulants. It has been said that deaths from thromboembolism can be abolished by ethyl discoumacetate (Tromexan ethyl

acetate), "but is death from hemorrhage, which is then to become the greater risk, to be favored because of a more tranquil end? It is rather ironical that pharmaceutical firms that supply a particular anticoagulant also provide their own brand of vitamin K so that Tromexan begets its Synkavite and Cumopyran its Hykinone. It causes us to think when the sale of a particular poison might be urged to boost the good offices of its corresponding antidote."

Some believe anticoagulant drugs are effective in preventing myocardial infarction when clinical symptoms indicate that the latter is impending. However, an analysis of 8 investigations into the incidence of thrombosis within the coronary artery circulation in patients with myocardial infarction examined at necropsy revealed an absence of such clotting in the coronary arteries in 57 per cent.²⁶ Moreover, Master and associates²⁷ have found a strikingly low incidence of subsequent myocardial infarction in patients with premonitory signs and symptoms who were treated with bed rest and conservative management without the use of anticoagulants. The realization that the anticoagulant treatment of thromboembolic disorders is a controversial subject brings up the question for the general practitioner as to how to proceed with his treatment of acute coronary occlusion. From the evidence, anticoagulants like other drugs appear to be indicated only under certain well defined circumstances. If he is not familiar with the action of these drugs or does not have the necessary laboratory facilities, he would be wise to abstain from their administration. If, on the other hand, he feels competent to apply such therapy he must use it with discrimination, according to the condition of his patients. He may follow those authorities who have a more aggressive attitude or others with a more conservative approach. In either case he need no longer fear to act under the courage of his own convictions.

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MEDICINE AND GENERAL SEMANTICS

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SUMMARY

The process of symbolization in medicine has become involved to the point where it would be pertinent to critically evaluate it. The discipline of general semantics, which involves a knowledge of linguistics, communication theory and logic, offers a method that is cogent and flexible. It may be applied to general medicine as well as to psychiatry.

e.g., vapor, liquid vestiges, or stray rubbish, in the container. The situation is named in one pattern (2) and the name is then 'acted out' or 'lived up to' in another (1); this being a general formula for the linguistic conditioning of behavior into hazardous forms."¹

The problem relates as well to the communication of ideas. Since a symbol may readily mean one thing for one individual, and another to the communicant, it is likely that some distortion of the message is likely to occur somewhere along the way. This occurs very frequently in the psychiatric interview. The role of the psychiatrist, in effect, is to reduce the message that is sent his way to some form that is more readily assimilated and understood, first by himself, and then by his patient. A message that contains no meaning may refer to a stream of words that are merely noise, or may be on a level of symbolization that is too complex to be handled by the receiver. Psychiatric concepts in general are characterized by a high level of symbolization, and for that reason are frequently distorted or rejected during transmission. Many of the ideas which we use in medicine, too, are of different content to the physician and to the patient. The term "hypertension" to the physician may mean merely an elevated reading of the sphygmomanometer, to the patient

IN medicine, as in all the sciences, ideas have become involved in a gradual increasing complexity of symbolization. This is to be expected in a field that is rapidly expanding and in which the number of ideas that are to be grasped become more numerous and, to a degree, more involved. We can at this level no longer refer, for instance, to the electrolyte balance which provides homeostasis but refer instead to terms such as "acidosis" or "alkalosis" to represent the failure of these mechanisms. The elevated blood pressure reading comes to denote the possibility of "hypertension" and certain respiratory notions of a complex nature are "asthmatic" or "dyspneic." This is, one might then postulate, to be expected from the structure of scientific endeavor; however, we are beginning to recognize certain pitfalls that arise as a result of an extension of these mechanisms in our communication forms.

Benjamin Whorf, whose pioneer studies in linguistics did much to carry the study of meaning from the field of the philosophers to the practising psychologist, very pointedly demonstrated how the language forms initiate actions which are erroneous and frequently disastrous.

"Thus around a storage of what are called 'gasoline drums' behavior will tend to a certain type, that is, great care will be exercised; while around a storage of what are called 'empty gasoline drums' it will tend to be different—careless, with little repression of smoking or of tossing cigarette stubs about. Yet the 'empty' drums are perhaps the more dangerous, since they contain explosive vapor. Physically the situation is hazardous, but the linguistic analysis according to regular analogy must employ the word 'empty,' which inevitably suggests lack of hazard. The word 'empty' is used in two linguistic patterns: (1) as a virtual synonym for 'null and void, negative, inert;' (2) applied in analysis of physical situations without regard to,

it may mean an inexorable course to increasing heart disease and terminating in cerebral hemorrhage. Physicians as a group have earned the reputation for being to some degree responsible for their patients' illness—indeed, a name, "iatrogenic illness," has accrued to some of the errors in judgment and ill devised explanations that physicians have given their patients.

Finally, one should be cognizant of the fact that there is usually a real difference between the dichotomy "true-false" and the dichotomy "right-wrong." As in the general philosophical enquiry, so in medicine does such a confusion exist and it seems to pervade our thought patterns so thoroughly that it merits a detailed examination. An elevated blood pressure is "bad," therefore it merits measures for its reversal. The value of a therapeutic means is measured by its effectiveness in accomplishing this reversal. As a consequence of this two-valued thinking, we are in medicine so preoccupied with the "treatment" and elimination of symptoms that we have lost much perspective in the management of the disease process as a whole. Since we have raised our abstractions to the levels where values dominate our decisions, we are frequently unaware that judgments based on values are influenced by cultural, e.g., moral, social, and religious factors that have little relationship to the situation at hand. It is hardly likely that a woman, two months pregnant, with German measles, will be treated by physicians of different faiths in a similar manner. But to carry the concept a step further, the treatment of the acute coronary episode is now as variegated as are the sects of various faiths. If we could conceive of a Tower of Babel existing today, it may be said to exist in many of our schools of medicine. The purpose here, however, is not the criticism of the variety of value judgments, but to assess the effect that such judgments have upon our evaluation of meaning and upon our treatment. Insofar as there are various values placed on symbols, it is certainly to be expected that misunderstandings will arise. This, in turn, leads to a general decay of the logic.

The analysis of these problems, i.e., symbolization, communication, value judgments, entails a search through epistemology, mathematical philosophy, probability theory, etc.—in general, the philosophy of science. The analysis however, need not be so thorough that it obscures value in the everyday verification of medical data.

Let us for a moment examine the medical interview. The patient presents himself with a complaint to the physician. The problem is in the patient's words clearly enunciated. He requires the physician to make an analysis and then to propose a solution. Hidden in this elemental situation are various pitfalls. The patient's symptoms are to be evaluated on various levels. Level A may be said to be the organ system affected. Level B may be said to be the patient as a whole, psyche and soma. Level C may be said to refer to the environment which provokes the symptom. All three levels may be said to be epitomized, symbolized and transmitted by the patient to the physician. But the weight that is placed on each level will certainly determine the form in which the symptom is conceived and consequently in which it is formally described. Here then, is the first stage in the semantic difficulty. In the presentation we are aware that what the patient says may not be what the physician hears. This need not necessarily be due to any technical difficulties. The ability of the patient to verbalize his difficulty, the ability of the physician to construct the words into a meaningful message may be factors as well. And finally, the level of symbolization may not be commensurate in each. The message reaches the physician, but here again, internal difficulties such as the three levels that affected the patient may influence him in its interpretation.

The general semanticist, for one, has recognized these many impedimenta to the interpersonal relationship, and suggests some practical expedients for avoidance of fallacies. He knows the value of the feedback in machines in the automatic control of functions and suggests that such a mechanism may be operative here. As one thoroughly "ventilates" a problem, corrections are made through self-regulatory mechanisms. By this means ideas may be analyzed in terms of facts and not necessarily of values alone. The relationship of factual data and value judgments becomes clear. The analysis proceeds through stages that are orderly and controlled.

In general, the semanticist proposes a discipline to closer relate our logic to reality. He postulates that many of the fallacies that arise in the evolution of our ideas are a result of the Aristotelian, two valued logic, as in the Law of Identity. Our language forms tend to encourage an either-or logic which is ill suited to the handling of scientific data. And, since we tend to confuse value judgments with facts, we are more subtly seduced into an idealism

that is diversionary and inappropriate. To illustrate, let us say that the patient presents himself with a headache. Our analysis of the genesis of the complaint and its relationship to the entire situation is impeded by the value judgment that this is "bad," and must be eliminated. Therefore, one must provide strong sedatives in order to destroy the symptom. We are then disheartened to find the patient return at a later date with a recurrence of the headache or with a new symptom. Either we continue to treat the new symptom or we turn the patient over to a specialist. The general semanticist sees the inherent difficulties in a two valued logic and proposes that we study the ways in which our language forms influence our evaluations, that we consider using a logic that involves probability considerations and that our treatment of data concern itself with facts before values are placed on these facts. The viewpoint has been adopted by many industrial psychologists with happy results. Applications in business and education have been proposed and adopted. It is in medicine, particularly in psychiatry, that we are most concerned and there is no doubt that the discipline has much validity. The theory of the neurosis has been effectively considered, for instance, by Wendell Johnson² who applies the technique in the treatment of speech disorders.

A. Korzybski³ conceived the general applications of the technique. He recognized that the separate issues involved were not new, but that the formulation into a workable system was new and applicable to medicine and education.

It is not to be construed that the technique of the general semanticist is intended to supplant the methods of medicine and psychiatry. It has its purpose to correct some difficulties that have accrued as a consequence of the linguistic and communication difficulties in any philosophical system. It is certainly not the final answer since the semanticist is susceptible to many of the errors of extension that he attempts to avoid. On the other hand, it is a serious and impressive elucidation of a problem that is becoming more and more urgent with the development of medicine as a science.

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INDICATIONS FOR RESECTION OR REMOVAL OF THE OVARY

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SUMMARY

In general we should be slow to operate when cystic feeling enlargements of the ovary are noted in younger women, and quick to operate in the woman "over 40" when any type of ovarian tumor is suspected.

When criteria indicating definite types of dysfunction are noted, many patients benefit from ovarian resection properly performed.

When neoplasms appear benign, resection of the ovary should be attempted more frequently and oophorectomy employed less routinely.

To date, there seems little reason to believe that more frequent routine examinations in an effort to find ovarian carcinoma early or more extensive resection when malignancy is found will materially improve the poor results now evident in the treatment of ovarian malignancy.

Prophylactic removal of both ovaries whenever pelvic laparotomy is indicated during the woman's preclimacteric years, if routinely and universally carried out, should reduce the number of deaths due

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to carcinoma of the ovary from nine to six or seven per 1,000 women. However, since less than one woman per hundred is now developing a malignancy of the ovary the advisability of such prophylactic oophorectomy should in all probability remain a question for some time to come.

I BELIEVE we would find, should we consult the newer textbooks, turn to the current literature or listen to the staff room discussion, that there seem but few differences of opinion regarding the indications to remove the ovary. It is surprising, therefore, since so little disagreement is usually expressed, that so much of the surgery being performed on the ovary, if viewed critically, still seems ill advised. Such criticism would, I believe, be due almost entirely to the fact that occasionally any one of us and some operators, much too frequently, treat dysfunctional cystic enlargements of the ovary as though they were true cystomas. We should also recognize, however, that the tendency to operate on dysfunctionally cystic ovaries is actually increasing and we must now admit that, if the criteria indicating certain types of dysfunction are appreciated, the resection of malfunctioning ovaries may prove beneficial over a considerable period of time.

The extent of the surgical intervention advisable when pathology affects the ovary continues to provide sources of controversy. Is ovarian removal necessary to minimize the likelihood of further disability when laparotomy seems indicated for pelvic inflammatory disease? How radical should we be when the patient is young and a granulosa cell tumor, a dysgerminoma or a teratoma seems limited to one ovary? Is more extensive resection indicated in an effort to improve our results in the treatment of ovarian cancer? Last but not least, and perhaps the most frequently considered today of all questions regarding ovarian surgery when pelvic laparotomy is indicated and the patient is approaching her climacteric, should normal appearing ovaries be removed as a means of preventing the possible later development of malignancy in the ovaries so carefully preserved? Certainly hospital tissue committees would like to know when the resection of nothing but normal looking ovarian tissue is justified. It seems advisable, therefore, that we occasionally review the trends for which, after all, we are largely responsible.

Pain frequently seems to indicate pelvic lapa-

rotomy but I believe that pain alone should seldom indicate operation on the ovary. When laparotomy has been performed because of lower quadrant pain, perhaps too often we hear that "nothing was found but a cystic ovary." Removing or resecting "a cystic ovary" under such circumstances has been condemned for years, but unfortunately the procedure too often provides a face saving indication for what might otherwise appear to have been an unnecessary laparotomy. This particular indication for ovarian surgery is mentioned only to again condemn this practice. In all probability the history of pain alone should not often be regarded as an indication for removal of the ovary. This is particularly true when examination fails to reveal tenderness sufficient to suggest peritoneal distention or irritation. Solid tumors of the ovary have been described as the cause of otherwise unexplained pelvic pain, but cystic enlargements of the ovary should be suspected as the cause of pain only when adhesions, torsion or so-called "prolapse into the cul-de-sac" seem to account for the reported discomfort. Actually it has long been our practice not to operate when a hemorrhagic ovary is suspected, and I really believe that laparotomy is indicated only when there is considerable doubt as to the diagnosis. Usually there are points in the history to suggest the probability of a hemorrhagic ovary rather than bleeding from an ectopic or torsion of the pedicle of a small cystoma and we should not forget that pain, when due to a hemorrhagic ovary, is usually the result of conditions which can be expected to disappear spontaneously and more rapidly than the discomforts which follow a laparotomy. Moreover, it has been our experience that resection of either physiological or dysfunctionally cystic areas in the ovary rarely relieves the source of a chronically recurring pain in either lower quadrant.

Ovarian enlargement is a frequent evidence of dysfunction but again there should be considerable question as to whether such enlargement indicates surgical intervention. When the patient is "over 40," the possibility of malignancy should be given first consideration, but in younger women we believe the physician who first discovers moderate degrees of ovarian enlargement should help avoid unnecessary laparotomies. Certainly if an ovary is to be removed, the operation should accomplish something more desirable than interruption of the life cycle of a cystic but non-neoplastic enlargement of the ovary. We would suggest, therefore, that im-

mediate operation is rarely advisable when enlargement thought to be ovarian and not greater than a 10 cm. "orange" is first noted in the pelvis of a woman less than 40 years of age. Much of the ovarian surgery, which later appears to have been ill advised, could be avoided if, before operation, more consideration was commonly given to such a simple rule.

If we are going to follow such generalities, obviously a few mistakes will be made. I believe it is fair to conclude, however, that only rarely will we be caught procrastinating with a dangerous neoplasm if we are slow to operate on cystic feeling, small ovarian tumors found in women under 40 years of age. On the other hand, we would agree to operate promptly when ovarian enlargement is appreciable "over 40" for the non-neoplastic types of ovarian enlargement are not likely to be discovered in older women.

Menstrual dysfunction may occasionally indicate ovarian surgery and while we may continue to emphasize the ineffectiveness and futility of ovarian removal because of cystic enlargements of the ovaries, we admit there are two well established entities which apparently justify the resection of ovaries, even though no pathology will be evident in the tissue removed.

(1) First, we may see the women with a history of prolonged periods of amenorrhea, usually scant menstruation when a period does occur and often "hot flashes." If she has a hypoplastic uterus and small barely palpable ovaries, which at operation appear well encapsulated without even blebs or nodules to indicate follicular development, menstruation may recur fairly regularly after not so much as a "wedge resection," but after multiple narrow strips have been peeled out of the capsule-like outer layers surfacing that little ovary.

(2) Second is a more generally acceptable and certainly more widely recognized syndrome suggested by the woman with a history of menorrhagia and metrorrhagia, or more classically evidenced by oligomenorrhea and the typical Stein-Leventhal syndrome, whose enlarged polycystic ovaries are readily palpable on examination. Here the classical "wedging" or "resection" often proves more effective than a long continued regimen of cyclicly given hormones.

Inflammation involving the ovary may still occasionally indicate surgery, although we know that

the usual course of pelvic inflammatory disease has been altered, indeed in many localities almost eliminated altogether by chemotherapy and the use of antibiotics. Salpingitis less frequently leads to tubo-ovarian abscess formation, and the cellulitis type of postabortive or postpartum infection now rarely results in the formation of a true ovarian abscess. It must be remembered, however, that even "wonder drugs" will probably be ineffective when disability, fever and pain are due to a well encapsulated abscess, and we believe the real ovarian abscess still indicates removal of the ovary. The more frequent problem, however, is that of deciding whether the ovary is or is not involved when recurring salpingitis or a pyosalpinx has seemed to indicate laparotomy. Falk¹ recently reporting effective techniques of dealing with the chronically infected tube, feels strongly that the ovarian tissue need not be removed, even when adjacent to a pyosalpinx, unless on bisection the ovary itself shows gross evidence of involvement or abscess formation.

BENIGN NEOPLASMS

INCIDENCE OF BILATERAL OCCURRENCE

When available data^{2,3} is reviewed in two series each reporting over 1,000 benign cystomas, the probability of the bilateral occurrence appears to be about as follows: dermoids 10.4–11.9 per cent, simple cystomas 6.6–9.3 per cent, serous cystadenomas 12–18.3 per cent and pseudomucinous cystadenomas 7.2–9.3 per cent. When a benign appearing cystoma seems unilateral, we therefore believe that the chance of bilateral occurrence indicates careful inspection, palpation and preferably bisection of the opposite ovary, even when the latter appears normal. We do not feel, however, that such a normal looking ovary need be removed purely because of the possibility that it may later develop pathology. Current concepts regarding the pathogenesis of ovarian neoplasms suggest that by the time an involved ovary has developed an appreciably large neoplasm, the opposite ovary if it shows no evidence of neoplasia on bisection would in the future be unlikely to subsequently develop a growth within the normal looking ovarian tissue we might choose to preserve. Moreover, our own follow-up studies to date indicate only a 2 per cent chance of any pathology developing in a preserved "other" ovary and published data suggest that less than half of those, or less than 1 per cent of women, ever develop a malignancy of the ovary.

CHOCOLATE CYSTS

In our experience the ovarian tumor most frequently encountered at operation is the "chocolate cyst" associated with endometriosis. In the management of this disease also we believe that bisection of the involved ovary rather than its removal should be considered even when only one side seems involved.

When both sides are involved both ovaries can be resected. Because of the probability that endometriosis involving an ovary represents a lesion that has been developing slowly over a number of years, portions of the ovary not grossly involved at the time of operation are not at all likely to develop new foci of endometriosis if the affected areas are carefully and completely excised. Moreover, we believe it is now generally agreed that the "chocolate" content of the endometrial cystoma does not contain viable cells that will implant if the contents are spilled onto the pelvic peritoneum; hence, there need be no consideration of oophorectomy in order to avoid the probability of such a spill.

DERMOIDS

Since the dermoids are the most frequent type of "true cystomas" found in younger women, we believe it is also important to consider ovarian resection rather than oophorectomy when a dermoid is encountered. Even a larger cyst apparently completely replacing the ovary will sometimes on bisection be found to permit excision limited to the involved portions of the ovary. We have, of course, been impressed by the severity of the so-called sterile peritonitis developing after the contents of a dermoid that has undergone torsion has been spilled onto the pelvic peritoneum. We have not noted evidence of such irritation, however, as a result of the spill that may result when a small or medium sized dermoid cystoma packed off from adjacent bowel is resected from an otherwise normal looking ovary.

CYSTADENOMAS

Usually occur at an age when preservation of ovarian tissue is less important. Our own observations suggest, however, that the danger of peritoneal implantation from a papillary cystadenoma inadvertently opened at surgery appears to have been over-emphasized. Whenever a benign looking cystoma is found in a comparatively young individual, we believe that an effort to resect the tumor from any portion of apparently uninvolved ovary is a proce-

dure that will usually seem fully justified during the patient's future course. At least in our material to date we have not observed the occurrence or recurrence of a neoplasm in the ovarian tissue preserved by resection of a benign cystoma.

SURGERY FOR MALIGNANCY IN THE OVARY

Malignancies in the ovary are generally regarded as a wholly unsolved problem. For example, let us consider for a moment that the "cure rate" when malignancy begins in the cervix or endometrium has been shown to increase in proportion to the percentage of relatively early cases treated. Moreover, the spread of cervical cancer is somewhat predictable and the problem is mechanical in the sense that treatment can often get ahead of the disease and affect a long time cure. On the other hand, while carcinoma arising in the endometrium seems relatively slow to break out of the uterus, once deeper invasion occurs and lymphatic involvement begins, biological factors seem predominant and the extent of spread is not predictable. Unfortunately, neither biologic nor mechanical factors seem to favor the patient when malignancy begins in the ovary. Growth is often rapid and not even peritoneal encapsulation of the ovary delays the dissemination of tumor cells onto adjacent viscera. Since the diagnosis is rarely suspected clinically, until signs appear which are due to extension beyond the ovary, it is remarkable that an average of nearly 20 per cent of patients seem cured for five or more years by present day surgery and irradiation.

The so-called primary carcinomas of the ovary comprise the largest group and are usually highly malignant. Growth and metastasis usually progress so rapidly that more than half of the patients in most reported series are dead of their disease within one year from the date the diagnosis was established. Follow-up studies indicate that overall five year survival figures are of little value in estimating the prognosis for the individual, who has but one of the variety of ovarian neoplasms. We believe it advisable, therefore, to briefly consider each of several more frequently encountered situations, wherein ovarian malignancy presents certain specific problems.

Preoperative irradiation has been suggested whenever an ovarian neoplasm is discovered in a woman over 50 years of age. Among the ovarian tumors we have first discovered in women over fifty years of age, however, approximately 40 per cent of such

tumors at operation have been found to be benign and even when ascites is noted in association with an ovarian neoplasm, we believe that irradiation is not advisable until the character of the pelvic mass has been determined by laparotomy and biopsy. Irradiation prior to an attempt at definitive surgical intervention may be employed, however, after an initial laparotomy has established the diagnosis.

Postoperative irradiation has for a long time seemed remarkably effective in an occasionally otherwise unexplained long-time survival.

"INOPERABLE WHEN THE ABDOMEN WAS OPENED"

The presence of peritoneal implantations and ascites does not contraindicate attempts to remove the primary mass. When extensive growth replaces both ovaries, if lines of cleavage can be found between tumor and adjacent loops of bowel, the mass can usually be removed. When uterus and adnexa are matted together and to the parietal peritoneum, time and blood may be spared by a retroperitoneal approach along iliac vessels and the ureters, permitting removal of the uterus, parametrium, tumor and much peritoneum in one mass. We need be concerned only with preservation of the larger vessels, the urinary tract, its blood supply, and that of the rectosigmoid. Exenterations have taught us that peritonealization of the pelvis will recur rapidly. When the rectosigmoid is involved its addition to the resected mass, and a colostomy, may increase the palliation accomplished.

Complete removal of the omentum will avoid the development of a distressing mass and decrease the reformation of ascitic fluid. Smaller tumor masses proliferating along parietal peritoneum may be peeled out of the pelvis as portions of the peritoneum are removed. The pelvic nodes will often be involved but in view of the probability of recurrences within the abdomen, an adequate dissection of pelvic lymphatics does not seem likely to improve palliation nor add appreciably to the patient's chance of long-time survival.

When the vascularity and extent of the growth suggest that primary surgical intervention is not advisable, at least biopsy specimens should be taken and even when the pelvic mass appears inoperable greater palliation may be achieved if the entire omentum is removed. Irradiation should then be given a trial and in some instances operability will seem markedly improved within a period of a few weeks.

When operability apparently improves we are inclined to believe that surgical intervention should be done as soon as improvement is clinically suggested, rather than deferred to see if time will substantiate the impression that irradiation has arrested the growth. At least it seems easier, and it is possibly wiser, to do any contemplated operation before postradiation fibrosis has become fully organized. We should not forget the possibility that viable neoplasm may be "locked up" in the fibrosis which follows treatment, and may seem to be released by operation in the tissues once so effectively irradiated. When no growth has been evident for months or several years, yet there is reason to suspect resectable residues of tumor within the irradiated tissue, perhaps "better leave well enough alone."

THE PATHOLOGIST WAS THE FIRST TO RECOGNIZE THAT THE OVARIAN TUMOR WAS MALIGNANT

Occasionally the surgical procedure may have been completed before the malignant character of an ovarian tumor is recognized. Involvement of only one ovary does not imply a relatively slow growing tumor; often apparently early neoplasms prove to be highly malignant. When the diagnosis of malignancy of an ovary is a postoperative surprise and only the one ovary has been removed, adequate operation should not be delayed. Reoperation and removal of the uterus, remaining adnexa, adjacent areas of peritoneum, and the entire omentum will improve the patient's chance for longer survival. Removal of palpable nodes along the iliac and ovarian vessels may provide significant information as far as the prognosis is concerned, but an adequate dissection of pelvic lymphatics would hardly reduce the probability of recurrence within the peritoneal cavity.

After operation, the probability that scattered tumor cells will remain viable is generally recognized and some form of prophylactic irradiation is usually given even though its effectiveness under such circumstances is difficult to evaluate. When ascitic fluid reforms or recurrences of tumor become evident, such treatment often proves surprisingly effective. Pleural effusion and pulmonary metastasis may temporarily recede as dramatically as intraperitoneal recurrences. Irradiation is always worth a trial.

Treatment within the abdomen and pelvis by means of activated gold in colloidal suspension provides a type of irradiation surprisingly well tolerated by almost all patients. The effectiveness of

such irradiation does not extend deeper than a millimeter or two into the tissues bathed by the suspension however, and "deep" Roentgen therapy is still advisable when there are appreciable masses of tumor to be irradiated.

THE RARER OVARIAN MALIGNANCIES

Such rarer but usually malignant tumors of the ovary as the sarcomas, mesonephromas, embryonic types of teratomas, dysgerminomas and granulosa cell tumors are often observed in adolescent girls or younger women. Since it is usually desirable to save the uterus and opposite ovary when the woman is young, no rules or generalizations can be made in regard to the management of such neoplasms. Individualization should be the rule, and whenever an ovarian neoplasm of questionable character is discovered at laparotomy, we believe it is advisable to call the pathologist or someone qualified to help to the operating room for immediate consultation at the table.

It is generally known that the ovary is peculiarly susceptible to metastatic growth. Certain malignancies, particularly breast carcinoma, seems most likely to metastasize to the ovary in younger women before their menopause. The discovery of metastatic tumor in the ovary seems a matter of prognostic importance only, however, for in most instances removal of the ovaries with their metastatic growth will not appreciably affect the malignancy of the primary lesion.

An apparently well encapsulated, or pedunculated tumor suggests less need to remove the uterus and opposite adnexa. It is a debatable decision but we do not feel the operator should be criticized for the "conservative management" of an apparently unilateral rarer type of ovarian malignancy in a young woman. The most radical management might also prove ineffective, and the conservative removal of only the involved ovary is sometimes followed by a surprisingly benign course.

Generally speaking, whenever a carcinoma of the ovary is discovered we believe that complete removal of the uterus and both adnexa is indicated. When an in-situ or very early stage I carcinoma of the cervix is discovered in a young woman, however, we feel that total hysterectomy with removal of adjacent vagina and parametrium, but preservation of at least one ovary, is a procedure that may eventually be recognized as good management of the individual, even though it may not seem the

best possible treatment of her carcinoma. By similar reasoning, however, in these sometimes highly malignant but not always so predictable ovarian lesions particularly, I doubt if anything approaching radical surgical intervention will prove worthwhile. For adolescent girls and young women with these rarer types of ovarian malignancies should life be made less tolerable by extensive surgical intervention or castrating irradiation when either might not be necessary, and both combined might still miss the foci of tumor which ultimately proves fatal?

Certain of the rarer ovarian neoplasms often seem benign. The extent of the surgery advisable when a feminizing tumor of the ovary is discovered, however, certainly permits of but few generalizations. Not infrequently the histologic picture of the granulosa cell tumor fails to provide a means upon which to base a reliable estimate of the prognosis. Recurrence many years after removal of apparently benign granulosa cell tumors are occasionally reported. Perhaps just as frequently, the histologically malignant looking granulosa cell carcinoma is recurrent only locally, and slowly. When only one ovary is involved and the patient is young, we feel that only the one ovary need be removed. However, the not infrequent association of these tumors to the development of endometrial carcinoma should also be remembered. Unless a chance of childbearing is particularly desired, perhaps the discovery of a granulosa cell type of tumor warrants removal of the uterus on a prophylactic basis even if the opposite ovary is not to be removed.

EARLIER DIAGNOSIS

Several possible approaches to the problems of ovarian malignancy seem to have been pretty thoroughly explored. Earlier diagnosis seems most desirable, particularly since experience gained by routine pelvic examinations and recognition of the earliest stages of cervical and endometrial malignancies have changed many of our ideas regarding the life cycle of pelvic malignancies. It now seems evident that at least cervical carcinoma may exist for years in a histologically demonstrable but clinically nonappreciable stage. It also seems apparent that at any time during those years such lesions, if detected, can be effectively treated and relatively easily "cured." Unfortunately, there seems but slight chance of discovering a malignancy of the ovary in an equally early and favorable stage. Detection of relatively early ovarian cancer might, however, occur in either of two situations.

(a) Among women complaining of pelvic discomfort, we would now agree that over 40, laparotomy would be indicated to determine the character of any suspected enlargement of the ovary.

(b) Among women examined without pelvic complaints, the chance of discovering an ovarian malignancy is exceedingly small, for it seems probable that each year not more than three women among each 10,000 "over 40" can be expected to develop a carcinoma in the ovary.

(c) What of the woman whose adnexa seemed normal when her pelvis was examined? How quickly may she develop a malignancy of the ovary? Would examination once a year increase the probability that ovarian malignancies would be picked up "early," in a relatively favorable stage? Probably not, for we have recently observed extensive peritoneal implantation and ascites in a woman whose pelvis had been regarded as completely negative only ten months prior to the discovery of "inoperable" ovarian carcinoma. Even when primary carcinoma is occasionally discovered incidentally in an asymptomatic stage the reported five year survivals approximate only 50 per cent, and there seems little reason to believe we can improve the situation merely by efforts to accomplish an earlier diagnosis.

OOPHORECTOMY FOR PROPHYLAXIS

We hear much today about the prophylactic removal of ovaries. A review of the indications for removal of the ovary as recorded in the literature, however, emphasizes the changing trends in such thought and practice. Not very many years ago oophorectomy was advised as a cure for emotional instability and insanity, whereas today we hear pleas for preservation of ovarian tissue as a means of helping maintain the woman's emotional stability. For many years castration was recommended as the simplest means of controlling excessive and prolong menstruation. Before the advent of effective chemotherapy, removal of the ovaries or castration by irradiation was recommended in the management of chronic infections, particularly pelvic tuberculosis.

Recently the indications for prophylactic oophorectomy seem to be decreasing and at the present time may be briefly considered under three headings: (1) the control of endometriosis; (2) to remove the effects of ovarian function upon certain malignancies, particularly adenocarcinoma of the breast; and (3) removal of the ovaries as a means of

avoiding the possible later development of an ovarian malignancy.

In some instances endometriosis seems so disabling that castration seems justified. Individualization is necessary, however, for endometriosis is quite unpredictable and we find that it is not often necessary to remove ovaries in order to control the symptomatology of this disease. Remembering particularly that the dysmenorrhea of endometriosis is usually associated with adenomyosis, and that a presacral neurectomy or hysterectomy will usually prove an effective means of relieving such pain, permits a more conservative management and the preservation of more ovarian tissue.

Discovery of the effectiveness of orchidectomy as a means of controlling the growth of prostatic malignancy seemed to justify renewed hope that oophorectomy might offer an equally effective means of controlling the spread of breast and endometrial carcinoma in the female. At least removal of the ovary often provides a variable period of symptomatic improvement in the progress of adenocarcinoma metastatic from the breast. However, removal of the ovaries has long been a part of the usual treatment of uterine carcinoma, and no change in the overall picture of uterine malignancy can be expected as the result of an appreciation of the theoretical advantages of withdrawing estrogen from the circulation of a woman treated for endometrial carcinoma.

The advisability of removing the ovaries prophylactically whenever hysterectomy is indicated, particularly in women approaching the age of their natural menopause, has become a matter of increasing interest.

Published data⁴ indicate that the probability of any woman developing a malignancy of the ovary approximates nine chances in 1,000. We recognize no factors which seem to predispose the individual to a greater than average chance of developing this neoplasm. The ineffectiveness of the methods of treatment now available, however, suggests that virtually all women developing ovarian malignancies will eventually die of the disease.

When benign disease indicates hysterectomy, particularly when the woman is approaching an age when her climacteric may be imminent, the surgeon must decide if a one per cent chance of developing ovarian carcinoma justifies removal of normal appearing ovaries. Several reports indicate

that approximately 20 per cent of the women eventually developing carcinoma of the ovary had been subjected to a pelvic laparotomy during their preclimacteric years. It would seem, therefore, that prophylactic oophorectomy, if employed routinely whenever laparotomy is indicated for women "over 40," might be expected to reduce the number of women eventually developing malignancies of the ovary from nine to seven per each 1,000 women over 40 years of age.

At the present time the effects of such prophylactic castration are not well known. It is evident to every clinician, however, that only a minority of women past their climacteric develop a degree of atrophic change productive of real dysfunction or discomfort. Perhaps after prophylactic removal of normal ovaries at the time of an indicated hysterectomy only a similarly small proportion of women

would develop discomforts due to postcastration changes. Moreover, replacement therapy is effective and can be inexpensive, so that the disadvantages of a prophylactic ovarian removal might be overcome rather easily in those few individuals who would really suffer as a result of estrogen deprivation following prophylactic castration.

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ARE PUBLIC RELATIONS NECESSARY TO A MEDICAL SOCIETY?

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MY personal answer to this question is an emphatic "yes." To illustrate one reason why I say this, let me tell you a little story:

A stranger dropped in at a country store in Tennessee just as a farmer came in and asked the storekeeper for a line of credit.

"Wilbur," said the storekeeper, "are you doing any fencing this Spring?"

"Yes, Uncle Jake, I am."

"Are you fencing in, or fencing out?"

"Fencing out, Uncle Jake. I'm taking that old wood lot, down by the creek."

"All right," said Uncle Jake, "go in and tell Henry to give you what you need."

The stranger said, "I've seen all kinds of credit systems, but never one like that. How does it work?" "Well," said the storekeeper, "if he's fencing in, that means the quackgrass and the broomsage and the sassafras is getting the best of him. If he's

fencing out, then it means he's whipping them. It means he's winning the fight. I always give credit to a man that's fencing out."

It is my feeling that a medical society such as ours should always be "fencing out," if we wish to win the fight and better the status of medicine. We can aid in this by improving our public relations. A recent AMA publication used the phrase "How to preach what you practice," which I feel expresses the problem we face. This is a timely subject since we in the medical profession will be more and more compelled to give it serious thought and expression if we wish to continue favorable public opinion about our medical care system and medical men in general.

Public relations have been defined by James Byrnes in his new book, "Public Relations in General Practice," as "the attitude and course of action taken by a person or group that wishes to identify its activities and purposes with the welfare of the

Retiring address of President of Hartford County Medical Association delivered at annual meeting in Hartford, April 5, 1955

people, in order to gain public understanding and good will." To apply this more directly to our county society, it covers any or all county activities which affect either the membership or the general public.

Some people may at first consider public relations as merely a method of promoting and spreading favorable publicity, whether an organization really merits it or not, a sort of questionable bally-hoo. They confuse public relations with publicity, with profitable business ventures, and even think of it as a white-washing campaign for our mistakes and failures. This, of course, is very far from the truth. We in the profession must have carried on individual public relations programs in the past to win and hold patients, or we could not have gained the confidence and respect we have enjoyed through the years. However, times are changing; complaints, whether justified or not, are pouring in, and increasing too are the constant threats of government control.

Dr. James P. Warbasse in his book, "The Doctor and the Public," has written, "Inadequate knowledge of the facts of medicine possessed by society leads people into costly errors. Inadequate knowledge of social facts possessed by doctors leads physicians into misunderstandings of their relations to society." It is here that public relations or, shall we say public service, as practiced by our county society is an aid to medicine as a whole, and to each individual member. In discussing the medical profession's inability to appreciate and understand public relations in the past, Fred Ware, an editor of the *Omaha World Herald*, stated that we could no longer be criticized for this fault; he felt the recognition of this failure, and our attempts to correct it had greatly improved the position of medicine. He remarked, "if you think clothes don't make the man, try walking down the street without any," and added with a little paraphrasing, "if you think doctors don't make any difference to a community, try living in one without any." These are kind words for us, but they only emphasize the need for better public relations.

In the world of business and industry, public relations are no longer considered a sideline, but a necessary function of management. Business has long realized the need of winning the good will of customers and community, a fundamental necessity in all public relations. Why should the medical profession feel exempt from the use of this aid to

understanding? In present-day life, our profession gives us no "holier than thou" position. Today there is a real necessity to win friends for medicine, to correct misconceptions, and to acquaint the public with the fact that we are doing a good job, and are striving to do a better one.

What can be done to accomplish this? A few basic points or program must be selected as a goal. A few years ago, some of our farsighted members did this very thing. Some may feel they have started a too ambitious program, but a good public relations program must be ambitious and, what is of equal importance, must be flexible, so that its individual points may be re-evaluated and changed as needed. In selecting a few basic components for a county society program, the AMA has depicted and evaluated several points which have been proven the key-stone of any program. It is not my purpose to discuss all these components, but I will deal with a few in which our county has had experience.

1. The Emergency Call Plan, or the provision for 24 hour emergency medical service.

Whether we feel it justified or not, the public now have come to expect that the medical profession must supply medical care in any emergency. What professional men and the lay public consider an emergency may be separated by a wide gap. Nevertheless, any failure to locate a doctor at once at the time of an accident or sudden illness brings forth the usual letters to the press, and to our committee on medical ethics and deportment.

These letters are evidence of bad public relations, and should and can be remedied. Attempts in our own county have on the whole been fairly successful, but have varied from town to town. Various plans have been used, and all have good points applicable to their particular locality. The two chief causes for a breakdown in this service involve:

- A. Inefficient telephone answering service. The usual commercial answering service may serve the individual physician well, but it does not have a sufficiently broad scope in its subscribers to be able to locate a doctor for an emergency during a 24 hour period.

- B. Insufficient participation of members in the emergency call system. These calls are frequently at inconvenient times for the majority of us. Many members, especially new ones, volunteer to take these emergency calls. We have found, however, that as a doctor's practice increases he no longer has the time or desire to answer emergencies, and

the system breaks down. In a county the size of ours, with several large cities and towns, this problem will probably be handled best in an individual way. Each district or area must have some sort of central telephone exchange, and there must be a larger member participation to make it successful. And we must make it successful, or be prepared for the brickbats of public criticism. These now come so frequently and, at times, painfully, that we can no longer find any protection in indifference.

2. A Committee on Medical Ethics and Deportment—or grievance, or mediations, or whatever you may wish to call it.

Such a committee affords the patient an opportunity to have his complaint reviewed, and provides him a sounding board for his grievance. Many of the complaints are unjustified, and are usually due to some dissatisfaction with the doctor's services or his charges.

Surveys have shown that fees, inadequate service, and general misunderstandings are the most common causes for complaint to this committee. We know there is sometimes an unfortunate lack of understanding among doctors themselves of the principles of medical ethics. Doctors are often very resentful of public criticism of their profession, and they are even more touchy about their fees. Some physicians feel that any evaluation of their services is the legitimate concern of no one but themselves. When this type of doctor charges a fee he cannot justify to the patient, he often displays, when confronted with this fact, evidence of a feeling of guilt, of defensiveness, at times of defiance. The committee functions as an arbiter here, and has often done so. By handling these disputes between doctor and patient, or even between doctors, and rendering a fair decision, we help to achieve that ideal situation when we eliminate the basis for complaints or disagreements.

Do not believe the criticism that these committees have no value but to whitewash members of the profession. Outwardly this may seem the case at times, probably because the committee lacks adequate power to give "teeth" to its decisions. Note the proposed changes in our by-laws on the duties and powers of our own committee.

3. Membership Orientation and Indoctrination.

This must include old as well as new members. Old members must be kept advised of the county society activities and an attempt made to draw them

into active participation. *The Bulletin*, issued monthly by our Association, attempts to do this. New members are welcomed at the annual and semi-annual dinners, and are presented with a booklet, "Guide to Membership," which we hope will help them familiarize themselves with the many activities and services offered to members of our Association. Under our proposed by-laws the new members will receive also a course in orientation at a series of meetings arranged by the Committee on Credentials and Orientation. Here they will be instructed in medical ethics, urged to attend meetings, to participate in an active way, and encouraged toward the achievement of ends beneficial to medicine, the public and themselves.

4. Attempt to Develop Good Press, Radio and TV Relations.

Most medical societies find this rather difficult. John M. Green, a Long Island Daily Press columnist, has remarked that the medical profession doesn't understand how far it can go in promoting, within the profession, better relations and cooperation with the press. He feels that we have been injuring our relationship with the public, and certainly have not endeared ourselves to the press, but he adds, "It is gratifying to the press to note that the doctors are trying." It would be equally gratifying to us if the press would try as well, and meet us at least halfway.

It is difficult for us, with our code of ethics and years of rigid ethical restrictions, to accept the "heartbreak" story or the sensational tragedy as they are presented to the public by press or radio. The press views these cases as of public interest, and will brook no editing of such stories by the medical profession. Such a policy might interfere with their idea of "freedom of the press."

On our part, we must learn to give out more general news about the profession in an attempt to build and maintain good relations with the papers, radio and television. A code of cooperation has already been outlined; it remains for us all to become acquainted with it and attempt to follow it. Good public relations depend upon the understanding and cooperation of every physician-member of the medical society. Each physician must be prepared to accept his individual responsibility for the success of the program and for maintaining good medical public relations. As you know, we have already provided these three news media with information to further public health education in

an attempt to produce better public understanding and appreciation of medicine.

5. A guarantee of medical care for all regardless of ability to pay.

This may at first seem rather radical, but on close examination such is not the case. We already give an almost unbelievable amount of free medical care each year. This we accept as a traditional responsibility to the medically indigent. According to our code of ethics, we are honor bound to give free care in such instances. We can help convince the public that we accept this responsibility of the profession, by a well planned form of publicity. Many fear that such publicity will only increase our load of free medical care, in fact may cause an uncontrollable avalanche. However, such has not been the experience of those who have tried it, and a fair number have. On the contrary, they have built up tremendous good will and improved public relations immeasurably.

The problem may be partially one of education, both of doctors and of the public, as to facilities available. If we can convince the public that an enlightened medical profession will provide medical care for all, regardless of ability to pay, we will have forestalled the argument for government intervention.

There are, of course, supplementary projects to this basic program. These, however, involve detailed description beyond the scope of this paper, but I trust I have awakened your interest to further your knowledge.

It is not for me to preach to better men than I am. But my work with the members of our Hartford County Association this past year assures me that the lessons we learn as we draw from the past will give us greater strength to meet the problems of the future in a way not dreamed possible even a decade ago.

ERYSIPELAS IN AN IMMATURE INFANT

A Case Report

NOAH BARYSH, M.D., *New Milford*

THE occurrence of agranulocytosis in newborn and young infants has been reported on four previous occasions by Givan and Shapiro,¹ Kato² and Slobody, Abramson and Loiseaux.³ In the excellent case report of Slobody and his co-authors, the clinical course of a newborn infant who, 75 hours after birth, developed an agranulocytosis associated with probable sepsis, is described. Treatment consisted of supportive and antibiotic therapy. It is interesting to note that the authors postulated "the concept of agranulocytosis as an anaphylactic or shock-like manifestation" with no proof, at that time however, to support this pathogenesis.

With the advent of steroid therapy the use of ACTH and cortisone was applied to the treatment of agranulocytosis. Recently, Durand, Flory and Hall⁴ reported on a combination of antibiotics,

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SUMMARY

The author presents what is believed to be the initial report in the medical literature of a case of sepsis (erysipelas) with transitory agranulocytosis in an immature infant who responded successfully to combined antibiotic, steroid and gamma globulin therapy.

From the New Milford Hospital

ACTH and cortisone in the successful treatment of agranulocytosis during pregnancy. These authors refer to seven (7) other cases of agranulocytosis treated with either or both of these agents.

CASE REPORT

L. B., a one month old white male infant, was admitted to the New Milford Hospital, April 6, 1955 in a state of shock. The infant was cyanotic, cold, breathing irregularly with Cheyne-Stokes respirations, with a pulse of 160 and a rectal temperature of 95°F.

The infant was born at the New Milford Hospital March 10, 1955, weighing 4 lbs. 10 oz. He was cared for by a local physician, remaining in the hospital three weeks, and was discharged March 30, weighing 5 lbs. 1 oz.

The baby was seen for the first time on the afternoon of April 6, having been referred by the family physician for a "rash on its face." The infant appeared moribund. He was cold, clammy, breathing irregularly; was unresponsive to stimuli. His rectal temperature was 94.5°F. He weighed 5 lbs. The left eyelid was swollen shut and the right eye less so. Purulent discharge issued from the inner canthi of the eyes. An erythematous macular rash, with raised margins, covered the forehead, the upper region of the cheeks and extended down the sides of the neck. The regional cervical glands were enlarged in a "bull-neck" fashion. Moist inspiratory rales were present over both lung fields. A tentative diagnosis of dacryostenosis, with secondary erysipelas of the face and neck, and terminal pneumonia was entertained. Epinephrine HCl (1:1000) 0.15 cc. was given and the infant sent to the hospital.

Information, pertinent to the possible etiology of the illness, was obtained that evening from the mother, wife of a migrant worker, who had come to live in New Milford at the time of birth of this baby. Upon discharge from the hospital one week previous to the present admission the youngster did reasonably well but 48 hours before the onset of this illness refused its bottle. A VNA staff member

making a routine call noticed the poor appearance of the infant and was especially impressed with the rash. She suggested that the mother take the infant to its family physician who, in turn, referred the baby to me. It appears that a sibling of the baby and the mother had both been ill with a severe sore throat which had responded satisfactorily to penicillin therapy just before the infant's present illness.

Immediately upon arrival at the hospital the infant was placed in an humidified, temperature controlled oxygen tent, given supportive fluid therapy, 600,000 units of a combined type penicillin (Bicillan A-P, Wyeth) and 0.5 cc. of gamma globulin. Culture of the discharge from the eyes and a complete blood count was done. At about 7 P. M. the initial blood report (Table I) was recorded. It was apparent that the infant had an overwhelming infection with limited granulocyte cell response. The infant was too enfeebled to suckle so that necessary fluids by clysis were administered.

At 4 A. M. April 7, 12 hours after admission, the infant's condition worsened. His temperature had dropped to 94° despite the application of local heat. He was breathing irregularly and rapidly. His pulse was difficult to palpate and heart tones were distant. In view of the desperate situation prevailing, steroid therapy was begun. Twenty units of ACTH gel and 50 mg. of cortisone dissolved in glucose water was given at that time by means of an indwelling polyethylene tube. Fluids, chiefly weak sweetened tea, were given throughout the night by the polyethylene tube route.

At 8 A. M. April 7 the infant appeared somewhat improved, although the brawny induration of the face and neck had spread to the chin area and resembled a Ludwig's angina. A white blood count taken that morning revealed complete absence of mature granulocytes, a gross diminution of lymphocytes and 88 per cent cells of the myelocyte and metamyelocyte group (see Table I). Thereafter the infant began to show definite clinical improvement, although on April 13 he had a flareup of his dacryostenosis. Sensitivity tests indicated that the organisms were in the nonhemolytic

TABLE I

DATE	APRIL 6 ¹	APRIL 7 ²	APRIL 8	APRIL 9	APRIL 10	APRIL 11	APRIL 12	APRIL 16
Hemoglobin	120%							
Erythrocytes per cu. mm.	5,110,000							
Leukocytes per cu. mm.	3,250	7,800	17,400	26,500	15,000	11,200	9,200	8,800
Small lymphocytes	46	9	6	20	36	54	69	73
Large lymphocytes	22	3	5	12	8	6	6	7
Transitional	—	—	—	10				
Large mononuclears	4	—		2	2	4	2	3
Polynuclear: neutrophiles	26	0	88	56	54	36	21	19
(Stabs)	(12)		(25)				(2)	
Eosinophiles	2		1					
Myelocytes		82						
Metamyelocytes		6						
Platelets	appear normal							

¹Initial blood count taken at 5 P. M.
²Subsequent blood counts taken at 8 or 9 A. M.

TABLE II MEDICATIONS	APRIL 6	APRIL 7	APRIL 8	APRIL 9	APRIL 10	APRIL 11	APRIL 12	APRIL 13
ACTH GEL Each sq = 20 units	*							
*Steroid therapy begun 4AM April 7								
CORTISONE Each sq = 50 mqs								
GAMMAGLOBULIN Each sq = 1cc								
A-P BICILLIN: Each sq = 500,000u								
AUREOMYCIN Each sq = 100 mqs								
CULTURE OF EYES	Non-Hemolytic Streptococcus-April 8							
Sensitivity Tests for Organisms	Penicillin-Resistant; Aureomycin-Very							
Cultured From Eye-April 9	Sensitive; Chloromycetin-Very Sensitive							

streptococcus group susceptible to Chloramphenicol particularly and resistant to penicillin. Accordingly the infant was treated locally with Chloramphenicol ophthalmic ointment and responded to this treatment. His diet during the early stage of his illness was a simple evaporated milk formula, vitamins and large (200 mg. daily) doses of ascorbic acid daily. His weight gain on this regimen was limited. He was then shifted to a fortified high protein whole milk formula with a subsequent rise in his weight. His skin began to peel over the involved areas on April 11, 1955. He was discharged April 18, eleven days after admission weighing 5 lbs. 15 oz. One month later he was re-examined at my office. He was completely well and weighed 8 lb. 10 oz.

DISCUSSION

One of the suspected causes of agranulocytosis is sepsis. In the infant described it appears to be the factor involved in that the baby had been in such intimate contact with persons sick with a streptococcal disease and the smears and culture of the involved eyes had nonhemolytic streptococci predominating. The concept that the sepsis may also have affected adrenal gland homeostasis is also advanced. The youngster presented all the signs suggestive of shock with associated depression in the circulating granulocytes. Whether this was due to "toxins" elaborated by the streptococci or whether this reaction was an actual adrenal insufficiency is hard to prove. It is of interest to note that for a two day period, after the administration of steroids, there was a transitory depression of the lymphocytes and an evident outpouring of the cells of the granulocyte group. This is in keeping with the effect of the administration of ACTH and especially cortisone in the diminution of lymphocytes and a pronounced but transitory neutrophilia in animals and man.⁵

The use of gamma globulin was based on the assumption that there is an inadequate supply of the gamma globulin fraction in the blood proteins of the premature and immature infant.

It was our impression that steroid therapy was especially helpful in the case reported.

CONCLUSIONS

The use of combined antibiotic, steroid and gamma globulin therapy was successful in combating erysipelas associated with transitory agranulocytosis in an immature infant. It is our belief that sepsis, probably inducing adrenal insufficiency, was the causative factor. It is our impression that the use of steroids, in addition to the known effectiveness of antibiotics and gamma globulin, tended to tip the scales towards recovery of this moribund infant.

Acknowledgment is made of the cooperation afforded me by the staff nurses, Mrs. Russell, superintendent of the New Milford Hospital, and Miss Katherine Horahan, R.N., medical technician, who cheerfully did daily white blood counts.

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ESSENTIALS IN THE HOSPITAL OF 1955

Team Work and Open Channels of Communication

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EVERYONE in the Connecticut Hospital Association must have spent many hours endeavoring to see if there is one common denominator in this current problem of hospitals in meeting well the needs of patients. However, the answer seems rather involved and it might be helpful to list a few of the influencing factors.

1. The tremendous progress in medicine and accompanying complicated procedures that have developed in the last decade or two.

2. The decrease in the length of stay so that practically all of the patients require concentrated attention and by skilled people, resulting in an increased number of admissions and a tremendous increase in the number of diagnostic and treatment procedures. (I always shudder when I have a report from our Central Supply Room indicating that they issue, on the average, three needles per patient per day.)

3. The decrease in the length of the work week in an effort to keep pace with other industries.

4. The elimination of the paternalistic attitude.

5. The increased compensation to all hospital workers and the change to a total cash basis with the result that nearly 70 cents of every dollar spent by hospitals is for people.

6. The fact that we have been working in a period when we are suffering from the low birth rate of 18 years ago. (It will be four or five years more before we begin to have a large number of girls reaching the age when they may apply to nursing schools. It will require ingenuity and cooperation to carry on until the 1942 crop of babies becomes eighteen.)

7. The impact of change on our doctors who were in the Service, and who hoped to come back and find things in medical practice just as they were before they went away, and the difficulty some of these good men have had in adjusting to some of the systems and procedures that have become neces-

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SUMMARY

Some of the problems are pointed out to indicate the structure that is necessary in good hospital management. This consists of the need for good leadership and interest in human beings, understanding of the steps necessary to maintain channels of communication, and assembly of people of good will and a constant drive to take every step necessary to accomplish the mission of better patient care.

sary as the hospital has become a more complicated entity and as the per patient day cost has spiralled.

8. The time lag in acceptance by the nursing profession of utilization of practical nurses and other aides. However, wonderful progress has been made in the last few years.

9. The improvement of personnel policies and shortening of the work week, which happened at a time in history when we were securing candidates for nursing schools from an era with a low birth rate, and we were not prepared.

10. The complicated problem of finance, particularly with relation to third party payment, and here I refer to Government and Blue Cross. This problem is probably greater in our New England area than in many other parts of the country. In certain parts of the country, hospitals such as your great Hartford Hospital would accept patients only if they could pay fully. Otherwise, these patients would go to a city or county hospital. This may be one of the penalties of the old hospitals in this portion of the country that are blessed with endowments and tradition on the basis of service to all.

It is more common for Blue Cross plans in such areas to pay the cost of care in semiprivate accom-

modations, whereas here in New England, in my judgment, we deal with as complicated a payment arrangement as it is possible to devise. In this connection I am reminded of the comment of one of the fine personalities in hospital work whom it was my privilege to know for more than twenty years. First, I knew her at the St. Elizabeth's Hospital in Boston, and some five years ago, Mother Evangelist, at that time director of St. Joseph's Hospital in Providence, said to me as we were spending an afternoon on hospital-Blue Cross relations: "Do you remember, some fifteen or more years ago, that we wouldn't spend an afternoon like this, that we devoted our time to our patients."

11. The task of the administrator becomes more complicated when things happen as I have enumerated and when we spend considerable time on building planning in order to develop efficient structures such as was accomplished in your present hospital, and such as I am currently working on. We are subject to the hazard, at such times, because of this pressure, of losing some of our contact with the people who make the hospital possible.

I have endeavored to hit some of the highlights, and I am sure that each of you could add to the list. Under such circumstances, what can we do to accomplish our aim which is better patient care?

I am sure that we are finding that the trustees of hospitals are giving more and more attention to this complicated enterprise. They are clearly recognizing the differences that prevail in a hospital as compared with an industry. The president of the Massachusetts Memorial Hospital is quoted as saying, "A hospital is unique among institutions in that staff doctors are independent of it and have no responsibility for its finances. Their professional responsibility towards the patient, like the financial responsibility of the trustee towards the donor, cannot be delegated. Such a division of responsibility is an organizational monstrosity; one that has troubled both doctors and trustees for years." Here is where our trustees must continue to be strong.

It is helpful to have good acceptance on the national level of a Joint Committee of Trustees of the American Medical Association and the American Hospital Association, and with your President, Dr. Snoke, taking an active part. They have done good work in clarifying the point of view that should prevail in this complicated organizational set-up. However, it takes a long time for this good work to

permeate and become accepted among nearly seven thousand hospitals and all their people.

It doesn't help when a member of the staff of a leading hospital goes on the circuit apparently to bring down the status of trustees, who by law have the responsibility. Such activities can easily negate the good work of people of good will who are sitting around the table in an effort to provide better patient care.

I compliment your organization in having members of the Boards of Trustees as active participants in this Association. It is by participating in meetings such as these, by reading the magazine *Trustee*, and by constant thoughtfulness on the part of the administrators that trustees can be adequately informed, and adequately informed they must be if the hospitals are going to face up to and solve the problems that seem to be commonplace today.

I had the pleasure of being on the program at the New England Hospital Assembly with the president of the New Haven Hospital, and the attitude of his Board towards its paid executive was most encouraging. This is the situation that must prevail. The president and the paid executive of the hospital must be of one mind, and the entire Board must be constantly at the right hand of its president and director.

To my mind this is the first and most important step to accomplish the objective of this conference. I would place next the Joint Conference Committee—and it must be with this medium that the members of the staff and the members of the Board of Trustees work together, and this Joint Conference Committee must work. We must find a way to have medical staff leaders carry the important message back to their staffs, or we will not attain our objective, and they must bring their thinking to the trustees in this Joint Conference Committee; in other words, chiefs must be good administrators as well as leaders in medicine and education.

We must also recognize and evaluate the changing relationships between physicians and nurses. Has the residents' and interns' place in patient care had an impact on this relationship?

In stating that this is the second most important step, I am assuming of course that the Board of Trustees has selected its medical staff and administrator wisely and that the members of the Joint Conference Committee work on a high plane.

We come next to the administrator of the hos-

pital—the chief paid executive of the Board of Trustees. Many people have written of qualities that this individual must have and I will not repeat them except to say that today he is working in a more complicated organizational structure and with more forces working with and against him than ever before. This paid executive must possess leadership skills as recognized in today's type of management.

It is in this area that the Council on Administrative Practice of the American Hospital Association has been working. Granted, its working committees such as Purchasing, Accounting, Housekeeping and Insurance are all important. As a matter of fact, the Insurance Committee, by wise action this year, has saved the hospitals of this country an estimated one million dollars in Workmen's Compensation payments. The Committees on Organization, Personnel and Methods Improvement are moving ahead with their assignments.

The Council has also been giving attention to the broad scope of management. I am sure that you have noticed advertisements by large corporations, indicating that they are seeking men with good potential for their executive training programs. At Packard Motors, Mr. Nance, introducing an executive training program, said that the country's shortage of top management talent is much more acute than any shortage of specialists, including engineers.

Westinghouse, in a report to top management, outlined a practical approach to management development. When asked a question: "What is back of your company's thinking in emphasizing management development?" the director of Management Development answered: "Our thinking is firmly grounded on the policy that the success of a man is the direct result of his own efforts and that no combination of company programs can propel him upward. But at the same time we do realize that the company can, and in its own interests should assist an individual. We do this by removing as many obstacles as possible over which he has no control and by making available to him pertinent development opportunities."

The American Management Association, in a recent publication stated: "Today's intense competition puts a heavier load on the personnel executive. His task is to translate the company philosophy of human relations into daily competitive action. His entire program must prove its hard-cash value—immediate as well as long range."

The New York State School of Industrial and Labor Relations at Cornell University, in a very current publication outlining programs for effective leadership, stated the objectives as follows:

"Cornell's four-week program of Human Relations in Administration supplements and complements the executive developmental activities within the organization. Specific objectives are:

1. To establish a clear picture of executive functions, responsibilities and relationships.
2. To identify the people problems that are met in carrying out duties and responsibilities.
3. To improve ability to analyze problems and take appropriate action.
4. To extend and improve working knowledge of human motivation and human relationships."

A new superintendent of buildings and grounds of a large hospital was called in to the laundry because a key piece of machinery needed repairs. The laundry manager is a keen administrator. He desires to let nothing interfere with his production schedule to have linen available for patients' needs in accordance with schedules outlined by head nurses who carry the responsibility.

This new buildings and grounds man approached the laundry manager by saying: "We are ready to go to work on your machine and we will do it to fit your schedule, and we will do it in such a way that your other operations will not be impaired." The laundry manager's statement to his superiors following this experience was: "I think our new buildings and grounds man will succeed because he knows how to handle people and he respects the responsibilities of the departments that he is here to serve." Is this not an example of the fact that 85 to 90 per cent of this man's job is human relations and 10 to 15 per cent is the technical know-how?

This American Hospital Association's Council's top job is to help provide the administrator with tools to aid him in becoming a better administrator. We must be top-flight administrators if we are to succeed in this field, and we must develop leaders in every area. A recent report in *Fortune* stated that two corporation presidents failed to meet minimum standards on tests for foremen: they got 50 per cent scores on "How to supervise." Why? Had they forgotten or been brought up in a different school?

To my mind this could be tragic in a hospital situation. We as administrators must keep close to

all of our supervisors, and we must set the pattern in our top management level that we wish to have followed in all levels of management in the hospital.

The hospital administrator, dedicated to his life's work, will need to earn the support of all the members of his organization. This he can do by developing a management committee, or a conference of department heads, and then in turn working with all of the supervisors of people in his organization. This working with people to have them understand the aims and objectives of the hospital, to have them feel a part of the hospital, to have them feel they are participating in the planning is essential if you wish them to carry out their duties successfully.

It is surprising how soon people forget or how rapidly our organizations change. For example, we took a group of supervisors and head nurses to see a nursing unit under construction in the new building, and two of the group had participated in the plan of the nursing station, the medicine and treatment rooms some four or five years ago, and on a full-size scale. And yet, when they saw the actual structures they expressed amazement. They were pleased to find that everything they planned had been carried out as they wished. This is one demonstration of the team approach in a hospital operation, and this team approach must prevail in the mind of the administrator and in the top management organization or its effectiveness on the nursing unit will be reduced substantially. It also proved the need for living up to one's statements.

The shortage of skilled personnel is fundamentally the product of trends in medical care which we neither can nor wish to reverse. The problem cannot be solved by maintaining the status quo and waiting for the return of the "good old days." The shackles of tradition must be cast off and all that goes on within the hospital must be analyzed objectively. The "team approach" as the technique of management is essential at all levels, and patient care committees within the hospital are a helpful device in meeting our objective of good patient care.

The National Joint Commission for the Improvement of the Care of the Patient was established in 1947 and, from doubtful beginnings, it has gained in stature and a goodly number of Joint Commissions on the State level are coming into being and functioning in the interest of the patient.

In reporting on the Massachusetts Joint Committee on Improvement of Patient Care, Dr. Maurice Fremont-Smith said: "It seemed to the committee that what was needed here was communication, that in each hospital better cooperative care could be achieved if better communication could be established between doctors, nurses and administration. The committee felt, moreover, that the limits of responsibility of the doctors and nursing groups needed discussion and clarification."

The group approach to the discussion of management problems is not a substitute for administrative decisions, but rather it is the technique for gaining understanding and acceptance so that out of such understanding comes better service.

A report to the Health Resources Advisory Committee, "Necessary Action to Reduce Personnel Requirements for the Care of Long Term Patients," stated that the central problems in the care of patients with either long term or short term illnesses are (1) how to see that each patient receives the right services at the right time, and (2) what organization of these services will be most economical of personnel. The subcommittee also recognizes that solving these problems would contribute to mobilization readiness (1) by restoring patients to maximum function as rapidly as possible, thereby either returning them to the labor force or reducing their dependence upon other people, whether these others be health personnel or other workers; and (2) by making possible better utilization of health personnel.

The committee's recommendation was that ways and means be considered to indoctrinate in the philosophy of rehabilitation medical students, nurses, hospital trustees and administrators.

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

Social Security — What it Means to Physicians

It can be expected that continuing efforts will be made by the Department of Health Education and Welfare and by others to extend Social Security coverage to more and more people. There will certainly be pressure to include physicians in the program during this and subsequent sessions of Congress.

The AMA House of Delegates has recorded its forceful opposition to Social Security coverage for the medical profession. Despite this fact there is a surprisingly large number of physicians who feel that they should participate in the program.

There always will be a small number who are dedicated to the general philosophy of the security or welfare state. There is a larger group who are uninformed about the subject and feel that they are being denied some sort of benefits to which they have a right.

It would seem worth while to examine some of the factors which pertain to this Social Security question. There are first a few philosophical considerations. The medical profession is generally reputed to be one of the last strongholds of what goes by the term of "rugged individualism." We feel we like to plan for our own futures. We take a dim view of compulsion and regimentation. We, for the most part, reject the ideology of collective security. These arguments fall in the realm of intangibles.

There are a few very practical aspects of the

problem such as the cost to us, and what we get for our money. What strings are attached to the deal?

As the act stands currently—and it changes rapidly—the cost for self employed individuals is 3 per cent of income up to \$4,200 or a maximum of \$126 annually. The 3 per cent figure is scheduled to increase. The upper income limit of \$4,200 will undoubtedly increase.

What would the physician get for his \$126 a year? In the event of his death his family would get a maximum of about \$180 a month. It might be of interest to note that the net cost of straight life insurance taken out at age 30 to provide a comparable income would be only about \$175 a year. These survivors benefits of Social Security have been the major reason for many young physicians to favor their inclusion in the system.

The retirement features of Social Security would be of no value to physicians. It has been established that there are almost no doctors who retire at age of 65. Inclusion in the Social Security system would not affect this situation. Under present provisions of the law the maximum retirement payment to a single beneficiary is \$108.50 per month. The recipient is allowed up to \$100 per month earned income. A total income of less than \$208 monthly will surely not find many takers in the medical profession.

It thus becomes evident that the Social Security system has little to offer physicians either in a philosophical or materialistic sense. To favor inclusion in Social Security would truly be selling our birthrights for a mess of pottage.

Dr. Crile and Cancerphobia

The controversy over cancerphobia highlighted by the article by Dr. Crile in a recent copy of *Life* and commented on by several leading physicians brings out into the open a subject which has been simmering beneath the surface for many a month. Regardless of whether the reader agrees or disagrees with the fundamental theme that the publicity on cancer is creating a reaction of fear, one must congratulate Dr. Crile on his philosophical approach to the problem.

Dr. Crile apparently intended to leave the layman with a realization of the value of modern cancer therapy and a deepening faith in his medical advisor, but the reactions of the public have not been of this nature in every case. Some have read into Dr. Crile's presentation a hopelessness in any form of therapy for the victim of cancer, while others see the continuing need for persistent watchfulness and attention to any symptom of an unusual nature.

The author has placed emphasis on the importance of cancer research. There is a growing number of physicians who feel that funds collected by cancer organizations can be more judiciously expended in this direction and not in the maintenance of detection clinics. The early recognition of cancer rests on certain basic principles, the alertness of the individual to his own symptoms and the individualized treatment of the patient by the physician. The early detection of cancer should be the responsibility of each physician in his office where only thoroughness of examination is to be condoned.

If cancerphobia has been engendered in the lay public through the many avenues of modern communication, the time has come for an evaluation of the entire program of cancer education. Life is very precious to every individual but, as Dr. Crile has said, it should not be measured in the number of years spent on this earth but in the fulness and accomplishment of one's lifetime.

Should Anticoagulant Drugs be Used in Myocardial Infarction?

Since the introduction of anticoagulant drugs into therapeutics for the prevention or treatment of thrombosis and embolism, there have been hundreds of published articles dealing with the numerous aspects of the subject. It would probably be a gross

understatement to say that the great majority of such articles have indicated by direct statement or implication that anticoagulants are an important, if not indeed an essential part of the routine treatment of acute coronary thrombosis with myocardial infarction. In the past several years an increasing number of experienced observers have questioned seriously whether these drugs have in fact fulfilled the expectations and claims of those who have advocated their routine employment in cases of such infarction.

The JOURNAL is fortunate in having the opportunity to present in this issue the illuminating, lucid discussion which many members of the Society heard when it was presented at the Clinical Congress a few months ago. Dr. Russek has become known throughout the cardiological world as perhaps the most articulate of those who are strongly opposed to the routine use of anticoagulants in myocardial infarction. His thoughtful discussion is warmly commended to all who have occasion to consider the therapeutic use of these drugs.

England's National Health Service — 1954

The report of the Ministry of Health for 1954 on the National Health Service in England and Wales contains some facts which should interest those of us who look upon this service with a somewhat jaundiced eye. The cost of general medical services in the total bill for the year amounted to only one-fifth of the cost of hospital and specialist services. Although the number of prescriptions issued dropped almost one million, yet every person in the country enjoyed an average of five prescriptions each at an average total cost for the five of one guinea.

One of the most striking facts which emerges from the present report, according to the *British Medical Journal*, is the reduction by about 50,000 (excluding mental and mental deficiency hospitals) in the number of persons on the hospital waiting lists. This is a ten per cent reduction and is the largest since the beginning of National Health Service. In spite of this reduction, the hospital waiting list in 1954 was 465,000.

Partnerships of physicians are on the increase, more than half of the new associations being of only two doctors.

The report states that there is no evidence whatever that there has been any deterioration in the

standard of service provided which might account for the increase in the number of claims and legal proceedings against hospitals and their staffs which has arisen. Other factors are cited as producing this increase.

The group of physicians known as the Fellowship for Freedom in Medicine and formerly headed by the late Lord Horder is conscientiously and actively looking for a way out of the present dilemma created by the establishment of the National Health Service. It has from the first admitted the impracticability of going back to the start and seeking a fresh route. It is convinced it will have to find a completely different way and that if the people of England and Wales remain under the present system all that is best in Medicine will be destroyed.

The bulk of the people in England seem to be satisfied with the National Health Service but our physician friends in the Freedom group point out that a patient seldom knows what is good for him, and when he does he hardly ever acts upon his knowledge. They also point out that the standard of medicine is going down and that the public must be educated to the fact that what they see as a swan is really a singularly ill-bred goose.

Finally, our friends are certain that the fault is not with the doctors nor with the patients but with the method and that if a method cannot succeed in six years it can never succeed. We shall watch with interest the attempts made to correct the present dilemma.

What's Wrong With This Picture?

When a magazine which once had several million readers finds it necessary or desirable to publish an article entitled "Why Some Doctors Should Go to Jail," the motivation may be ascribed to a failing circulation. However, when the general pattern is repeated elsewhere with no protest from the public, we must suppose that the writers have found a receptive audience. Indeed, there is ample evidence to suggest that this is a case. Not so long ago we found it necessary to spend a million dollars to protect ourselves from the chain-gang existence of socialized medicine. That experience was a shock treatment—in spades—for many physicians who, because they were sincerely interested in the welfare of their patient, had imagined that their sentiments were reciprocated. Clearly the relationship between the physician and the public he serves has

grown increasingly unsatisfactory in the past decade or two. The problem is admittedly involved and neither partner is free from responsibility for its development. But no justification exists for a fatalistic, devil-may-care attitude nor for the protest that the difficulty is insoluble. Naturally it will not be solved by the physician who is "too busy" to receive his patient courteously, to take an adequate history or to make a sufficiently detailed examination.

The problem will not be solved by engaging a public relations expert if he is expected to defend borderline practices employed by the few on the fringe of the profession who furnish the majority of our headaches. We can't make the problem evaporate by presenting a paper every year or two at a county meeting, nor by reading an editorial like this one.

It may be desirable to consider the establishment of a postgraduate course in public relations which will be urged on all physicians and perhaps made compulsory on new registrants. In the meantime, probably there are a few of us who could be occasionally more considerate, less hurried, more patient, less abrupt and infinitely more appreciative of our professional privileges.

A 17 Gun Salute

Those of our readers who can hark back to the early days of the JOURNAL may remember the interesting and instructive writings on the medical aspects of deep sea diving contributed by Charles W. Shilling, then Lieutenant Commander, Medical Corps, USN, stationed at the Submarine Base in New London. Not only was Dr. Shilling an interesting writer, but he proved himself a captivating speaker at medical society meetings and a worthwhile friend by arranging visits to the Sub Base with its fascinating diving tower.

Lieutenant Commander Shilling has come a long way since those days of World War II. Promoted to captain, then retired recently after 28 years of service, Dr. Shilling now holds an appointment as special assistant to John C. Bugbee, director of the Atomic Energy Commission's Division of Biology and Medicine.

To one who qualified as a deep-sea diver, who served successively as director of the medical sciences division, deputy for bio-sciences, and special assistant for bio-sciences in the Office of

Naval Research, and finally as director of the research division of the Navy's Bureau of Medicine and Surgery, this new honor is most deserving.

Connecticut physicians may be justly proud of the attainments of a former resident of our State. The JOURNAL salutes you, Dr. Shilling!

Gift of Hope

Those Christmas Seals in gay holiday colors are here again, a welcome sight to these old eyes. They've been a part of the Christmas season as long as we can remember.

They started small. Forty-nine years ago \$3,000 was raised to fight tuberculosis in the first Christmas Seal Sale. Each year they have done a bigger job, and we're beginning to see real progress against tuberculosis.

Perhaps the greatest progress made has been in decreasing the number of TB deaths with modern treatment. Death rates, however, don't tell the story. The living man—or woman—who has TB is the problem. Progress in preventing cases of TB has been slow and sometimes discouraging. Each person who has TB must be found, treated and helped to keep well so that he will not break down again. His personal and family problems, his job, his mental and emotional attitudes toward the disease, the community's attitude toward him—these matters are all vital to the control of tuberculosis.

We know that tuberculosis can be prevented. With adequate funds to apply fully the preventive measures we now have to find even better measures, tuberculosis can be brought under control.

Each of us can help speed that day by making a generous contribution to the Christmas Seal Sale. Each Christmas Seal we use is a gift of hope that will narrow the gap between what could be done and what will be done to win the battle against tuberculosis.

G. B.

Our readers may turn with interest to the September, 1955 issue of *The Yale Journal of Biology & Medicine* and read "Reminiscences of an Old-Time Doctor." This is an account of Dr. George Blumer's active life from the day he entered Cooper Medical College in San Francisco to the present years of his retirement at San Marino, California.

Many physicians in Connecticut will remember

Dr. Blumer as Dean of Yale Medical School and as John Slade Ely Professor of Medicine. He is a constant contributor to the JOURNAL where his interesting editorials may be found over the signature G. B. Through all his many years his pen has continued to produce discussions on a wide range of medical subjects, from the first decade of this century when he turned out an editorial a week for the *Journal of the American Medical Association* to the present day when he graces our pages with his words of wisdom.

Fever Prevention Study

Inauguration of a study to establish criteria for streptococcal control in the school population as a basis for community rheumatic fever prevention programs all over the nation has been announced by the American Heart Association. The study, which will involve participation of 2,900 children in three Philadelphia elementary schools, is being conducted by the Heart Association of Southeastern Pennsylvania in cooperation with the national Association and local groups.

The study is designed to fill important gaps in knowledge about control of streptococcal infections. Earlier studies in a military population have demonstrated the efficacy of prompt and adequate penicillin treatment of streptococcal infections in preventing initial rheumatic fever attacks.

The Philadelphia study is the nation's first controlled effort of its kind designed to yield information on the behavior of the streptococci in causing infections that may be followed by rheumatic fever. This information will provide a basis for determining the most effective and most practical methods for controlling streptococcal infections in a school population. Among the streptococcal diagnostic procedures that will be evaluated is the use of throat cultures.

The study will continue for at least one year. A report on the results will be made after a sufficient time has been allowed for followup and a careful review of the findings.

Director of the study is John P. Hubbard, M.D., professor of preventive medicine at the University of Pennsylvania Medical School, who is assisted by David Cornfield, M.D., of the Department of Preventive Medicine and Pediatrics in the same school.

THE PRESIDENT'S PAGE

THERE is an old saying: "An honest confession is good for the soul." As you know, I have believed wholeheartedly and actively participated in the development of a medical care program in Connecticut. This was realized in our Connecticut Medical Service. At the beginning I, as did many other physicians, signed up as a participating physician. I must confess I then sat idly by paying little attention to its subsequent development and activities.

One of the responsibilities of your President is to serve on the Professional Policy Committee of CMS. Up to this time I did not realize what a remarkably sound organization our CMS is. As you know, CMS began its operation in 1949 and from the very beginning there was no question about its success. Its destiny is guided by a Board of Directors composed of six physicians named by our Council, and six experienced business men who are dedicated to the service of their fellow man. This group is ably assisted by a Professional Policy Committee who gladly give their time to be certain the medical profession and the recipients of medical care give and receive the services indicated.

The first meeting of the Professional Policy Committee I attended was a revelation to me. I became acquainted with the tremendous scope of CMS activities and wish each of you could have been observers at an actual meeting. The Director of CMS presents to the committee the problems he and his staff are unable to solve, such as questionable medical claims, fees, etc. It is gratifying to hear and observe the clarity of discussion and clearcut disposition of these matters.

As actuarial experience and reserves are accumulated, the Board of Directors recommend to the committee, for consideration, new and broader service coverage for their subscribers. These recommendations are thoroughly studied in order to formulate proper policy for rendering the best services to all parties involved.

The Annual Report for the year 1954 is a brief, concise document which tells its up-to-the-minute story. It shows a growth in six years from 199,505 to 865,941 subscribers. Checking the Financial Statement of 1954, subscribers paid \$8,547,883.04 for premiums. The administrative cost for processing subscribers' claims and paying for the medical services amounted to 12.3 per cent. Altogether 81.3 per cent or \$6,949,562 was paid to physicians for services rendered. If you are not one of the 2,373 participating physicians, it is definitely to your and the subscriber's benefit to become one.

With the approach of the Yuletide season may I take this opportunity to wish you and yours a very Merry Christmas and may the New Year be a bright and happy one.

O. L. Stringfield, M.D.

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October Council Meeting

A regular meeting of the Council was held at the offices of the Society on October 19, 1955. The meeting was called to order by the chairman at 4:00 P. M. There were present in addition to the Chairman, Dr. Fincke, Drs. Stringfield, Couch, Barker, Weld, Danaher, Feeney, Gallivan, Tracy, Russell, Archambault, Clarke, Meyers, Buckley, Dwyer, Gilman. Absent: Drs. Ogden, Murdock, Gibson, Marvin, Ursone, Flaherty, Ottenheimer, Gens, Starr.

The establishment of an award of some kind for past presidents of the Society was discussed and it was voted that the chairman appoint a subcommittee of the Council to inquire into this subject and report at a later meeting of the Council. The committee was appointed as follows: Chairman Thomas M. Feeney, Ralph L. Gilman, Walter I. Russell.

It was voted to appropriate \$300 from the unallotted funds of the Society to finance the First Connecticut Conference on Physicians and Schools that will be held at the Hamden High School on November 9 under the direction of the Committee on School Health.

A letter from the State Commissioner of Health which had been distributed with the Agenda for this meeting was discussed at length. In the letter the Commissioner had expressed the desirability of the deletion of "and the same principles and regulations as now exist for other biologicals furnished by the State Department of Health" from the policies relating to Poliomyelitis Vaccine Distribution and Use that were adopted by the Council on September 15, 1955. It was pointed out that the clause referred to was incompatible with Federal regulations which had been promulgated by the Public Health Service and which states that no means test or other discrimination based on financial ability of individuals will be imposed to limit the eligibility of persons to receive the vaccine against poliomyelitis. It was

finally voted with one dissent that the clause referred to be deleted from the September 15 action of the Council.

Dr. Arthur Ebbert, Jr., chairman of the Society's Committee on Postgraduate Education, joined the meeting at this time and presented a report of the Committee on Postgraduate Education on the 1956 Clinical Congress. The highlights of the report were: Comparative figures of paid registration, members of the Society and other practicing physicians in recent years were: 1952 598; 1953 481; 1954 423; 1955 374. Non-members: students, interns, etc., 1952 221; 1953 255; 1954 222; 1955 315.

Receipts — 1952 \$1,868 — profit — \$185.52; 1953 \$1,510 — deficit — \$297.55; 1954 \$1,310 — deficit — \$455.63; 1955 \$1,122 — on basis of bills paid to date there is a \$300 deficit.

It is estimated there is \$250 outstanding in bills not yet received. Estimated total deficit for the year \$550. After deducting this amount the past accumulated surplus of the Clinical Congress fund amounts to approximately \$2,400.

Dr. Ebbert then presented the following recommendations from the Committee for the 1956 Congress:

1. A two day Congress should be planned for a date early in November.
2. Since the November date will conflict with the medical school schedule, arrangements should be made to hold the Congress at the Statler Hotel in Hartford if possible.
3. In addition to two simultaneous, general morning sessions and one general afternoon session each day, specialty section meetings should be arranged for the afternoons and evenings (expenses of the section programs will not be assumed by the Clinical Congress, and physicians attending only the section meetings will not be assessed the usual registration fee).

4. Registration fee for the 1956 Clinical Congress should remain three dollars.

It was voted (a) that a Congress should be held in 1956, (b) that the date of the Congress be held early in November if a suitable place can be found to hold it, and (c) that the Committee hold the Congress at the Statler Hotel, Hartford, as recommended and report to the Council at its next meeting on November 10 preparatory to making a recommendation to the House of Delegates meeting on December 8.

Dr. Carl E. Johnson, chairman, and Dr. William H. Horton, members of the Building Committee, joined the meeting and Dr. Johnson presented the report and architect's plans for the proposed addition to the Society's building. The report was supplemented by explanation of details by the executive secretary and the project discussed by many. Proposals were also presented for means of financing construction of the addition, the cost of which had been estimated at approximately \$57,000, by the utilization of surplus funds of the Society or a building fund to which members of the Society would be asked to contribute in the same manner as the original building fund of the Society was operated for the construction of the original building. It was voted to accept the proposals made by the Building Committee and that an opportunity be given to the members of the Society to contribute to the building fund and that the Committee present definite plans for further procedure to the Council at its meeting on November 10 preparatory to submitting it to the House of Delegates meeting on December 8.

A resolution from the Committee on Public Relations relating to disaster emergency plan. Copies of correspondence in regard to this subject had been distributed to the members of the Council just before the meeting. The whole subject of the medical aspect of disaster relief was discussed in many details with particular reference to the Society's responsibility in this connection. It was finally agreed that the Society has a moral and public responsibility in planning and carrying out relief in disaster whether it be caused by military action, civil commotion or accident, or natural causes. It was voted that the president of the Society should call and conduct a community conference on the medical phases of disaster relief and invited to this conference should be the State Commissioner of Health, the State

director of Civil Defense, the director of Health Service and Civil Defense, representatives of the Connecticut Hospital Association, the Surgeon General of the State Military Department, representatives of the American Red Cross, the chairman of the Society's Committee on Emergency Medical Service and such other persons as may be appropriately included.

Twenty-three students members were elected.

The meeting adjourned at 6:15 P. M.

November Council Meeting

A regular meeting of the Council was held at the offices of the Society on November 10, 1955. The meeting was called to order by the chairman at 3:30 P. M. There were present in addition to the Chairman, Dr. Fincke, Drs. Stringfield, Ogden, Couch, Barker, Weld, Danaher, Feeney, Gallivan, Ursone, Tracy, Russell, Archambault, Gens, Meyers, Buckley, Dwyer, Starr, Gilman. Absent: Drs. Murdock, Gibson, Marvin, Flaherty, Ottenheimer, Clarke.

It was voted to comply with the request of the United Cerebral Palsy Association of Connecticut and appoint a Medical Advisory Committee to the Association as follows: Chairman John F. Paget, Bridgeport; Ward J. McFarland, New London; Cole B. Gibson, New Haven; Thomas F. Hines, New Haven.

The budget for 1956 was presented and explained by the Treasurer Dr. Couch. It was unanimously voted to recommend the budget as presented by the Budget Committee to the House of Delegates semi annual meeting on December 8 and that the dues for 1956 be continued at \$28. Dr Couch proposed that during the coming year the Council direct its attention to a discussion of salary standards for clerical and secretarial employees. This was agreed to but no definitive action was taken.

A report of the Connecticut Regional Blood Program prepared by the chairman of the Society's Blood Bank Committee, Ralph E. Kendall, was presented and Dr. Victor G. H. Wallace, director of the Bank was present to discuss the report. It was voted that the Society endorse a resolution previously adopted by the AMA affirming the principle that "there should be no profit from traffic in whole blood itself, but that the costs of services necessarily involved in the use of blood should be paid for by the recipient of such services."

It was voted that the chairman appoint three members of the Council to meet with the Blood Bank Committee for further exploration of plans for the future operation of the Blood Bank. Chairman, Dr. Danaher; Dr. Tracy, Dr. Weld.

Dr. Fincke, chairman of a special Subcommittee to present plans for a loan fund for interns and residents, reported. The proposals made by Dr. Fincke were approved for recommendation to the semi-annual meeting of the House of Delegates on December 8.

Deficit appropriations to meet over-spent committee allotments were approved as follows: Allotment for the Committee on State Legislation was increased from \$300 to \$650 and the allotment for the Committee on Foods, Drugs, Cosmetics and Devices was increased from \$100 to \$135.

A report of the Committee on Building Expansion was presented, discussed and unanimously adopted with a minor change concerning the size of the Building Committee and the following recommendation will be presented by the Council to the semi-annual meeting of the House of Delegates on December 8.

1. That the Society proceed at the earliest convenient time with the enlargement of its building, in accordance with the plans submitted by the architect and approved by the Council.

2. That the project be financed by voluntary contributions from members of the Society, supplemented by utilization of surplus funds of the Society to meet the total cost.

3. That the Building Committee appointed by the president in compliance with the vote of the House of Delegates on April 26, 1955, be enlarged to include representation from all parts of the State.

Dr. Gallivan presented a progress report of the Subcommittee on the Report of the Hospital Committee. The report was accepted.

The procedure concerning appropriation for meeting pro rata expenses of the Clinical Session of the AMA to be held in Boston on November 29 - December 2, 1955 was discussed at length. It was voted that the chairman of the Council report to the House of Delegates on December 8 that the Council had approved a contribution from the Society to meet, with the Medical Societies of the other New England States, a pro rata share of the expenses of the Boston meeting and that the treas-

urer of the Society be authorized to expend funds of the Society to meet this pro rated cost.

A resolution was presented from the Eye, Ear, Nose and Throat Section, explained by the executive secretary and discussed. It was voted that the Council submit the recommendation to the semi-annual meeting of the House of Delegates on December 8 without recommendation as to the contents of the resolution but with the recommendation that the resolution be referred to a Reference Committee of the House.

Excerpts from the minutes of a meeting of the Committee on Public Health on November 3, 1955 were presented as follows: "It is the opinion of the Committee that all approvals of consultants to the State Consultant Service should continue to flow through the Committee on Public Health of the Connecticut State Medical Society. Passed unanimously. The secretary was charged to call this to the attention of the Council." It was voted that no action be taken upon this action of the Committee on Public Health and that the executive secretary be directed to ask the Committee on Public Health to provide the Council with further explanation of the intent and purpose of this action. "It is the considered opinion of the Committee on Public Health that Board eligibility should not be a formal stipulation (for appointment as consultants) because there are occasionally well qualified men who do not wish to become board members. Passed unanimously. The secretary was charged to call this to the attention of the Council." It was voted to approve this action of the Committee on Public Health. "We recommend to the Council that a communication be sent to Dr. Oliver L. Stringfield, chairman of the Governor's Advisory Committee on Poliomyelitis vaccine requesting that the committee expand the eligible age group beyond 5-9 years, in keeping with the amount of vaccine now flowing into the State. Passed unanimously. The reasons given by the members were:

1. Vaccine has a short dating period.
2. Not all of the 5-9 age groups are availing themselves of the vaccine.
3. Because of the 7 month interval between 2nd and 3rd shots, further delay will mean that many injections will again fall in the summer time.
4. The 5-9 age group is not a static group; there are children entering and leaving this group daily.

It will be impossible to say that all members of the 5-9 age group have been done completely.

5. Since the present polio season is now over, there will be no group that has a higher incidence than other groups since practically no exposures will be taking place until the next season rolls around; it will be hoped that enough vaccine will have flowed into the State to cover many other age groups."

Dr. Stringfield, chairman of the Governor's Advisory Committee, reported that the Advisory Committee had already directed the Commissioner of Health to extend the age limits for the use of vaccine from 5-9 to 3-12 years as soon as there was sufficient vaccine in Connecticut to cover this extended use. In the light of this statement, no action was taken on the recommendation from the Committee on Public Health and the secretary was directed to inform the Committee of Dr. Stringfield's report.

A supplementary report on the 1956 Clinical Congress was presented by Dr. Ebbert who joined the meeting of the Council at this time. Dr. Ebbert stated that information given in a previous report concerning the expense of holding the 1956 Congress at the Hotel Statler in Hartford was the result of inadequate information.

On further exploration it had been found that the expenses of the meeting at the Statler would be approximately \$600 for the use of facilities and he wished direction from the Council as to how to proceed with planning for the Congress in 1956. It was voted that the Committee go ahead with plans for the Congress at the Statler in Hartford for early November, that the registration fee of the Congress be increased from \$3 to \$5 and that the Committee prepare to meet any deficit incurred from the accrued surplus in the Clinical Congress fund. The secretary of the Society was directed to explore the possibility of having a small and selective commercial exhibit.

It was agreed that the Nominating Committee should hold its first meeting Thursday, January 12, 1956 at 3:30 P. M.

Twenty-five student members were elected.

The next meeting of the Council was tentatively set for Wednesday, January 18, 1956.

The secretary presented an encouraging progress report on the health of Dr. James D. Gold.

The meeting adjourned at 6:15 P. M.

Student Members Elected October 19, 1955

C. Redington Barrett, Jr., Greenwich
Columbia University—1959
Pre-Med: Yale University
Parent: C. Redington Barrett

Richard Joseph Cardines, Hartford
Johns Hopkins University—1959
Pre-Med: Trinity College
Parent: Nicandro J. Cardines

Robert Anthony Ciarcia, Waterbury
Georgetown University—1959
Pre-Med: College of the Holy Cross
Parent: Joseph M. Ciarcia

Jerome Thomas John Combs, Wallingford
Johns Hopkins University—1959
Pre-Med: Yale University
Parent: Stanley M. Combs

Alan Standish Dana, Jr., Ansonia
Johns Hopkins University—1959
Pre-Med: MIT
Parent: Alan Standish Dana, Sr.

John J. Davenport, Jr., New Britain
Georgetown University—1959
Pre-Med: Holy Cross College
Parent: John J. Davenport

Richard A. Duchelle, Hamden
Georgetown University—1959
Pre-Med: Fairfield University
Parent: Francis J. Duchelle

James Herron Halsey, Jr., Bridgeport
Yale University—1959
Pre-Med: University of Bridgeport
Parent: James Herron Halsey

Carol Ruth Jockers, Darien
Yale University—1959
Pre-Med: Wellesley College
Parent: Harold W. Jockers

Harold Katzman, West Hartford
Jefferson Medical College—1959
Pre-Med: Trinity College
Parent: Dr. Samuel Sidney Katzman

Willard Arthur Krehl, North Haven
Yale University—1957
Pre-Med: Cornell College and University of Wisconsin
Parent: Fred John Krehl (not living)

Harold David Levy, Branford
 Boston University School of Medicine—1959
 Pre-Med: Yale University
 Parent: Nathan Levy, M.D.

George Mastras, Middletown
 University of Vermont—1959
 Pre-Med: University of Connecticut
 Parent: Gost Mastras

Peter Myers Molloy, West Hartford
 Yale University School of Medicine—1959
 Pre-Med: Williams College
 Parent: Francis P. Molloy

Joseph Francis Palma, Winsted
 University of Vermont—1959
 Pre-Med: St. Bonaventure University
 Parent: Carmelo Palma

Edward Anthony Palomba, Waterbury
 Georgetown Medical School—1959
 Pre-Med: University of Connecticut
 Parent: Deceased

James Donald Prokop, Easton
 Yale University—1959
 Pre-Med: Yale University
 Parent: George A. Prokop

Henry John Ramini, Jr., Meriden
 Vermont Medical College—1959
 Pre-Med: Wesleyan University
 Parent: Henry John Ramini

David Pardee Reed, Naugatuck
 Yale University—1959
 Pre-Med: University of Connecticut
 Parent: Harry A. Reed

David Dolcort Sachs, Westport
 Tufts University—1959
 Pre-Med: Columbia University
 Parent: Alfred Sachs

Kenneth B. Snell, Orange
 Boston University—1959
 Pre-Med: Dartmouth College
 Parent: Cullen B. Snell (deceased)

Charles Stanley Walkoff, Norwalk
 George Washington University—1959
 Pre-Med: Union College
 Parent: Harry Walkoff

George Campbell Wilson, Jr., Norwich
 Columbia University—1959
 Pre-Med: Yale University
 Parent: Dr. George Campbell Wilson

Student Members Elected November
 10, 1955

Frederick H. Anlyan, Hamden
 Boston University—1959
 Pre-Med: Yale University
 Parent: Armand Anlyan

Michael M. Conroy, Meriden
 Cornell University—1959
 Pre-Med: Yale University
 Parent: Michael J. Conroy, M.D.

Henry J. Cutler, Waterbury
 New York Medical College—1959
 Pre-Med: Yale University
 Parent: Frank A. Cutler (deceased)

Ronald C. DeConti, New Britain
 Yale Medical School—1959
 Pre-Med: Yale University
 Parent: Louis R. DeConti

Peter Demir, Waterbury
 New York Medical College—1958
 Pre-Med: University of Pennsylvania
 Parent: Quazin Demir

Brian A. Dorman, Danielson
 New York Medical College—1959
 Pre-Med: Trinity College
 Parent: Albert V. Dorman

Stanley P. Filewicz, New Britain
 New York Medical College—1959
 Pre-Med: Trinity College
 Parent: Stanley A. Filewicz

David M. Geetter, Hartford
 Jefferson Medical College—1959
 Pre-Med: Trinity College
 Parent: Isidore S. Geetter, M.D.

Gordon G. Globus, Norwich
 Tufts Medical College—1959
 Pre-Med: Cornell University
 Parent: Dr. Robert Globus

Philip John Griffin, Cheshire
 Yale University—1959
 Pre-Med: University of Connecticut
 Parent: John P. Griffin (deceased)

Harold P. Higgins, Norwich
 Tufts University School of Medicine—1959
 Pre-Med: Middlebury College
 Parent: Harold W. Higgins, M.D.

Armin T. Keil, Stamford
Northwestern University School of Medicine—
1956
Pre-Med: University of Connecticut
Parent: Ernest A. Keil

Gary E. Leinbach, Wallingford
Cornell University Medical College—1959
Pre-Med: Williams College
Parent: Earl G. Leinbach

George P. Lord, New London
Tufts University School of Medicine—1959
Pre-Med: U. S. Coast Guard Academy
Parent: Franklyn T. Lord

Brian J. McGrath, Hamden
Yale University—1959
Pre-Med: Yale College
Parent: John P. McGrath

Joseph T. Ostroski, New Britain
Tufts Medical School—1959
Pre-Med: Tufts University
Parent: Joseph C. Ostroski

Silvio F. Pace, Hartford
University of Rome—1952
Resident Hartford Hospital
Parent: Ludovico Pace

William T. Prifty, Waterbury
University of Rochester—1959
Pre-Med: Brown University
Parent: Charles A. Prifty

Joan C. Rushen, Bristol
Woman's Medical College of Pennsylvania—1959
Pre-Med: University of Connecticut
Parent: Frank T. Rushen

Richard M. Senfield, Derby
Yale University—1959
Pre-Med: College of the Holy Cross
Parent: Maxon M. Senfield, M.D.

Phillip E. Trowbridge, Hartford
Tufts University School of Medicine—1959
Pre-Med: Trinity College
Parent: John H. Trowbridge (deceased)

Joseph V. Uricchio, Jr., Hartford
Cornell University Medical College—1959
Pre-Med: Amherst College
Parent: Joseph V. Uricchio

Robert E. Waugh, Storrs
Yale University School of Medicine—1959
Pre-Med: Dartmouth College
Parent: Albert E. Waugh

John F. R. Wegrzyn, Bridgeport
Marquette University School of Medicine—1959
Pre-Med: Tufts College
Parent: John F. Wegrzyn

David R. Widrow, Versailles
Columbia University College of Physicians &
Surgeons—1959
Pre-Med: Yale University
Parent: Moses Widrow

New Members

HARTFORD COUNTY

Robert J. Alesbury, Manchester
Chester F. Culien, Hartford
Helen O'Brien Cullina, West Hartford
Evans H. Daniels, Jr., Hartford
Charles R. Hamilton, Jr., Manchester
John H. Houck, Hartford
Daniel E. Mack, Windsor
Thomas J. Madden, New Britain
Mather H. Neill, Hartford
J. Kenneth T. Ormrod, Hartford

MIDDLESEX COUNTY

Charles W. Chace, Middletown
Franz X. Hasselbacher, Middletown

NEW HAVEN COUNTY

Harold David Batt, West Haven
Richard Baz, Milford
Joseph R. Bergen, Waterbury
Carl Butenas, Meriden
Ronald Eliot Coe, Hamden
Larry L. Feder, Waterbury
Philip C. Holzberger, Meriden
Nicholas M. Green, New Haven
Samuel P. Hunt, New Haven
Sidney Hurwitz, West Haven
Seymour R. Lipsky, New Haven
Hans W. Loewald, New Haven
Robert Grant Nims, West Haven
James Thomas Nixon, New Haven
Timothy Francis Nolan, West Haven
Stewart Judson Petrie, New Haven
Martin Lewis Pilot, New Haven
George Rollins Read, West Haven
Eugene Leon Serafin, New Haven
Charles Kazimir Skreczko, New Haven
Kenneth Clark Steele, West Haven
Virginia Mae Stuermer, New Haven
George Rodney Walker, New Haven
William Welch Winternitz, New Haven

TOLLAND COUNTY

Joseph John Kristan, Rockville
 John Leonard Phiffer, Rockville
 Victor Gerard Sonnen, Hazardville
 Vernon Everette Thomas, Rockville

Full-Time Positions

There are three interesting full-time positions available for physicians in Connecticut. One—clinical. Two—administrative. Information can be obtained from the Secretary's office.

Wisconsin Dedicates New Administration Building

More than 200 persons attended the dedication ceremony October 15 of the new \$375,000 administration building of the State Medical Society of Wisconsin.

The beautiful structure, which has 17,000 square feet of space on two floors, is situated on Lake Monona, three miles southeast of Madison's downtown area. The two and a half acre tract includes a parking lot for nearly 100 cars.

The Wisconsin Society, which was established in 1841 and has a membership of 3,200 physicians, dedicated its new headquarters with a fine program, including addresses by AMA President Elmer Hess and Dr. Gunnar Gundersen, La Crosse, Wisconsin, chairman of the AMA Board of Trustees.

Meetings Held in November

- November 2—Connecticut Health League
Committee on School Health
- November 3—Committee on Public Health
Subcommittee on Physicians Employed by Hospitals
- November 7—Conference Committee with Pharmaceutical Association
- November 9—Committee on School Health Conference on Physicians and Schools
Subcommittee on Toxemia
Advisory Committee to State Welfare Department
Committee on Hospitals
- November 10—Council

- November 14—Cornell Crash Injury Project
- November 15—Conference Committee with State Dental Association
Woman's Auxiliary
- November 16—Committee on Neonatal Mortality
- November 17—Committee to Study Third Party Payments for Medical and Ancillary Non-Surgical Services
- November 18—Program Committee for Annual Meeting
- November 22—Connecticut Medical Examining Board
- November 23—Connecticut Heart Association
- November 28—Connecticut Health League
- November 30—Committee to Study Maternal Mortality and Morbidity

 THE DOCTOR'S OFFICE

Melville Y. Alderman, M.D. announces the opening of an office for the practice of diseases of the skin at 600 Asylum Avenue, Hartford.

Deal T. Aseltine, Jr., M.D. announces the opening of an office for the practice of general surgery at 350 Farmington Avenue, Hartford.

Arnold Fieldman, M.D. announces the opening of an office for the practice of cardiology at 52 Whitney Street, Hartford.

H. David Frank, M.D. announces the opening of an office for the practice of internal medicine at 881 Lafayette Street, Bridgeport.

Donald R. Hazen, M.D. announces the removal of his office for the practice of medicine to 50 Farmington Avenue, Hartford.

Philip J. Moorad, M.D. announces the establishment of the New Britain Neuropsychiatric Clinic. Practice limited to neurology, psychiatry and geriatrics at 69 Lexington Street, New Britain.

Joseph P. Shea, M.D. announces the opening of an office for the practice of thoracic surgery at 743 Washington Avenue, Bridgeport.

Leonard K. Smith, M.D. announces the opening of an office for the practice of plastic and reconstructive surgery and surgery of the hand at 36A Woodland Street, Hartford.

Special Article

THE NEW ENGLAND HOSPITAL

International Educational Program for Women Physicians

MANY have come to believe that ultimate world peace is far more dependent upon economic adjustment and individual wellbeing than upon political ideologies, and that it will be brought about only when the focus of world planning turns away from mass psychology and is brought to bear on the essential dignity and importance of every individual, with emphasis upon worldwide education.

On this premise, the educational program for women physicians now being established on an international basis by the New England Hospital has both immediate and long range implications; it suggests a practical solution of the present worldwide imbalance of medical education and opportunity for advanced medical training, as well as pointing towards a larger, more visionary goal of international health.

To clarify the New England Hospital's particular interest in this international program, a brief review of the hospital's history and chartered purposes is necessary, as well as a summary of the present situation in hospitals in this country and abroad.

The New England Hospital was founded in 1862 by Dr. Marie Zakrzewska, who had come to America from Poland seeking equality of opportunity for women in medicine, a vision that became reality with the establishment of this hospital. Here "Dr. Zak" and her contemporaries labored many years to create for women physicians a hospital where educational opportunities in medicine were available to them at the highest levels.

The hospital, formerly known "For Women and Children," was chartered in 1862 with three specific purposes: the advancement of women physicians, medical care of women, and training of nurses. A decade later, in the initiation of a nurses' training school, the hospital again assumed leadership in a pioneer movement, and in 1873 Linda Richards received her diploma from the New England Hospital to become "America's First Trained Nurse."

The ensuing years have seen many changes and advancements in medicine and in hospital adminis-

tration throughout the country and, in its own growth and advancement, the New England Hospital has been flexible in its leadership and has shifted its emphases to meet the changing needs of the broad community it now serves, while retaining a peculiarly individualized quality of service for which it is warmly remembered by generations of patients.

American women have now achieved a measure of equality in the field of medicine, and opportunities for internships and some residencies are now available to them in most hospitals in the United States. However, high ranking staff positions are not generally open to them except at three hospitals, one of which is the New England Hospital. At the present time the active staff there is entirely composed of women, while the large courtesy and consulting staffs include both sexes.

At present, in this country, only 6 per cent of our medical students are women. In many other countries today, the number ranges from 10 to 50 per cent, because of the great necessity for additional women physicians—in many instances by virtue of religious beliefs and customs. However, while medical education in schools is available to them in their own countries, there are not sufficient hospitals, nor qualified staff and teachers, to provide the advanced education in residencies and internships that is necessary to round out their experience and knowledge.

Recognizing the need for such advanced training opportunities, the New England Hospital Trustees and Staff are making a comprehensive educational program available to qualified women physicians from other countries, with the thought that it will be a forward step in extending the frontiers of good medical care, especially for women, throughout the world.

The International Program being developed at the New England Hospital is not, however, merely a numerical expansion of the normal house officer program. It is a pioneer effort in that it will be

especially geared to meet the particular social and psychological needs of the foreign house officer in addition to medical training needs.

With some six thousand foreign students annually in this country, experience has shown that certain common problems arise in connection with their adjustment to our customs and language. Although a working knowledge of English is a prerequisite for acceptance, their English is seldom fluent, nor are they familiar with idioms or, essential for our training purposes, with medical terms. This language barrier in turn creates other problems: confusion, insecurity, lack of social contacts, and inability to gain the maximum from their training opportunities.

This new program will anticipate these needs. A month's indoctrination and orientation will be required prior to the year's medical training, and will include an intensive English course, demonstration of medical techniques used in this country, and medical terminology, drugs and medications unfamiliar to them. A tour of the city's art museums and other places of interest is also planned.

Contacts with local international groups have been made so that each house officer will have an opportunity to meet people of her nationality and participate in social functions with students from all parts of the world. These agencies will also be available to them for assistance in personal matters.

Any program, to be successful, must be mutually advantageous. The New England Hospital will render valuable service in extending such a program and, in turn, the New England Hospital and its patients will have the advantage of good house officer coverage, which means providing good medical care.

Above and beyond the mutual advantages, the medical staff of the hospital intends to offer total scholarships up to \$5,000 a year for ten women physicians to insure an equal opportunity for all qualified applicants, regardless of their economic status. This money will be used to defray traveling and other expenses to this country.

This unusual teaching program will also include a 36 week course given at the hospital, in basic sciences and current advances in the field of medicine. Four field trips to some of the famous local hospitals and special clinical conferences each month with outstanding physicians in the Boston area will be arranged. It is also hoped that arrangements with

other hospitals for additional years of study in the specialty of their choice can be made.

It seems highly appropriate that the New England Hospital should assume the leadership in international education of women doctors because of its 93 years of experience in the training of women physicians, specializing in the medical care of women. This program has been designed not only to offer the highest standards of medical training but also to demonstrate the value of democracy of education.

It is realized that this is but a small step in world-wide education, but each step in the right direction is progress. World health and world affairs are obviously linked together, and, as progress is made in the one it is felt that a concrete contribution will be made to the other.

The Washington-Rochambeau Celebration

Several Hartford physicians took a prominent part in the recent celebration commemorating the first meeting of General George Washington and Lieutenant General Jean Baptiste Donatieu de Vimeur, Comte de Rochambeau, at Hartford on September 20, 1780. The chairman of the general committee was Marcel Thau and serving with him on this committee were Asa J. Dion, Raymond T. Houle, H. Gildersleeve Jarvis, J. Whitfield Larrabee, Louis F. Middlebrook and Maurice F. O'Connell.

Dr. Dion was chairman of a committee whose function it was to issue a commemorative brochure. This appeared with a cover in the French tricolor and contained an historical account of the first Washington-Rochambeau meeting by Drs. Middlebrook and Dion, an account of the founding of the Society of the Cincinnati, and an historical sketch of the First Company, Governor's Foot Guard. The brochure is attractively bound and well illustrated and between its covers may be found greetings from our President, Dwight D. Eisenhower, Governor Ribicoff, Mayor De Lucco and the Adjutant General of Connecticut, Major General Reincke.

The authors of the historical sketches, Drs. Middlebrook and Dion, are to be commended for their interesting accounts. Hartford now has a Rochambeau Square with a commemorative tablet erected at Hotel Statler. Indicative of the stormy days of the American Revolution, the weather man did his best to make the celebration a wet one.

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*REG. U.S. PAT. OFF.



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THE HISTORIAN'S NOTE BOOK

TYPHOID FEVER IN BRISTOL

A. S. BRACKETT, M.D., *Riverside*

Most of what I am recording is what has come under my own observation. When my father brought his family to Bristol in 1876 there were no sewers or public water supply. We got our water from an out-of-doors well, and had the privy outside the house. As my father rented a house on hilly Divinity Street the house above us also had an outside privy, which drained down hill. The topography of the town together with many cases of typhoid which were mild and undiagnosed, plus healthy carriers, resulted in a condition that caused typhoid to be called "Bristol fever." Shortly after we came to Bristol I had a fever lasting two or three weeks which may have been due to the typhoid bacillus.

In 1888 my father moved to Hartford and I went to Yale College and after graduation went to medical school in Philadelphia. After graduating and getting my M.D. I interned in the Methodist Episcopal Hospital. There we had a portable tub into which we put our typhoid cases, with ice floating in the tub.

I went back to practice in Bristol in 1896 and soon was called to see a young woman with typhoid fever. I found her in bed with several blankets over her. On the stove was a kettle containing potatoes. These were mashed and put into two cylindrical bags which were put under the bedclothes while warm. Of course the result was that she was perspiring and was most uncomfortable.

As Bristol was a homeopathic town I knew that I would be watched closely. So I told the husband that I didn't think he would approve of my treatment. He said to go ahead. I had them take most of the bed clothes off and give her a tepid bath every three hours, to which alcohol was added. I have forgotten what medicines I gave her but I am sure they neither helped nor hurt her. She was soon better and much more comfortable and recovered nicely.

In another case the father's shop mates told him

that I would kill his son. Fortunately he lived. Later I was called to a family where six children from eight months to fourteen years old were sick. One of the older ones had an intra-abdominal abscess. Dr. E. R. Lampson from Hartford operated in the home and drained it. They all recovered under the devoted care of a Miss Kirby. There were no screens on the doors or windows, so the flies came in from the outside privy. There were two more houses nearby where the same conditions existed with the same result: numerous cases of typhoid.

An epidemic of typhoid fever occurred in Polkville (now Edgewood) due to the water supply being infected, and another one later when the water supply became infected from a water pipe which was broken where it crossed an infected brook.

An old lady told me that she had typhoid, but was not allowed to have any water. She overheard the doctor say that she could not get well; I suppose following the old saying, "Stuff a cold and starve a fever." When night came she got up and drank a whole pitcher full of water and recovered.

My own grandmother told me that when a young woman her father had taken her back home. I knew that she had gall stones, which suggested that she probably at some time had typhoid.

Dr. George S. Hull informed me that before the water company was organized and sewers were installed, his fees from typhoid cases covered his overhead expenses.

Old records from 1793 to 1860 show cases of "typhus" most of which were typhoid.

It has been years since I have seen a case of typhoid. In all I must have treated between fifty and seventy-five cases with one death. Treatment consisted of a strictly milk diet with tepid baths when the temperature was above 103°. They lived but looked like picked chickens afterwards.

TRIP TO ISRAEL

Part II. The Kibbutz

(Part I appeared in November Issue
under authorship of Peripateticus)

RICHARD KARPE, M.D., *Hartford*

WE rushed through the places of classical antiquity, Rome and Athens, with the speed of the American tourist, regretting that we could not see everything more leisurely, and finally reached Israel, where we intended to stay for three weeks. We wanted to divide our time between participation in a medical conference and contact with my psychoanalytic colleagues on the one hand, and on the other hand, we wanted to learn more about a new social form, which developed in the last four decades in Israel.

Four per cent of the Israeli population live in collective agricultural settlements with a completely new approach to problems of income, property, and family. 70,000 people from a population of one and three quarter million is quantitatively not a very large segment, but their devotion, idealism and social consciousness makes this small segment a very significant group. There exist serious questions about the development and future of this group in the face of the present political and economic conditions. Does this institution of the collective settlement fulfill only a transitory function in the pioneering phase of colonization, or will it, as a superstructure over the family, become a permanent part of a developed and stabilized economy? Whatever the answer to this might be, there is no question that, as a spontaneous social experiment, it is of great importance for anyone who is interested in the intricacies of human group psychology.

I stayed with my family, my wife and three young children in Sarid, one of the collective settlements which are called Kibbutz. Sarid consists of a population of about 600 people who share their property and income without reservation. They consider the problems of bringing up the children the responsibility of their collective and in this way change the function and the tasks of the family as an institution. As marital stresses play a great role in the problems of individual adjustments, this new social form must make its imprint on the psychodynamics of intra- and interpersonal conflicts.

A three week stay in such a collective, interrupted

by sightseeing and attendance at medical meetings, is again too short a time for anything more than an impression. The economic standard of life is low in regard to food, clothing and amusements, but the cultural level as regards to books, music, education, and discussions is very high. The medical level is high in spite of an abundance of flies, which are annoying but harmless. The drying out of the swamps had terminated the dangers from the destructive malaria. Refrigeration is limited to the community kitchen and therefore there is not enough cold water available in the summer heat, but the hygienic conditions of that kitchen are superior to many hotels.

The interest in the application of psychoanalysis to educational, sociological and medical problems is great but hampered by the shortage of qualified personnel. It is misleading to assume that the fact that the children live in separate houses estranges parents and children. The children's houses and the residences of the parents are very close to each other and much time is available for an intensive contact between parents and children, free from disciplinary problems. We were very much surprised over the high degree of identification shown by those children who grew up in the kibbutz, with the ideals of their parents. Practically all of those who were born there wish to remain in their native kibbutz or go out to found new ones, but they do not move away to the cities.

Both boys and girls join the army immediately after finishing high school and serve for two years. Only part of their time, however, is used in actual military training. A great part of their time in the army is used for work on new frontier settlements. The army also helps to integrate immigrants from many lands speaking many different languages, into one nation and one language, namely, Hebrew. The idea of the melting pot is even more effective in Israel than it is in our country. After their army duty, the kibbutz members either go back to the kibbutz of their parents or they join a new group and start new settlement points, many of them

taking part in the colonization of the desert. Two-thirds of a river in central Israel is being piped into the Southern desert to irrigate the desert and to transform arid sterile land into abundant tropical vegetation reminiscent of a "South sea paradise."

The contact between the Jewish and Arab citizens of Israel is an intensive and friendly one and, if left in peace, the members of the kibbutz could become the avant garde of a new Middle Eastern community. The group whose hospitality we enjoyed believes in the possibility of sincere friendship and cultural cooperation with their Arab neighbors. They are organizing Arab youth groups who work in their villages for higher cultural standards and peace.

The tourist's contacts with the Israeli youth is impaired by the language problem as the main and only language used by the young native of Israel, called "sabrá," is Hebrew. English is taught and learned in school but not easily spoken by the sabrá. Hebrew is difficult to learn for the American tourist but the nonverbal language of the kibbutz is impressive enough to transmit to the visitor the beauty and vitality of an ancient land teeming with the promise of a great future.

Graduate Medical Education Shows Big Gains

Training programs for newly graduated doctors have become as big—in terms of enrollment and time spent—as basic medical school education, it was reported recently.

It is believed that this situation is unique among the professions, according to the Council on Medical Education and Hospitals of the American Medical Association.

Enrollment of young physician graduates as interns and residents for the 1954-55 year passed that of students in undergraduate medical schools, the council said, noting that this is an indication of "the magnitude of the growth of graduate training over the past 10 years."

The council's annual report on internships and

residencies showed 9,066 graduates serving internships for 1954-55 and 20,494 serving as residents, a total of 29,560 in 1,364 hospitals. This is an increase of about 2,500 over last year, according to the report in the September 24 *Journal of the AMA*.

Internships offered show for 1954-55 a 250 per cent increase over the number reported in 1914, the first year approved hospitals were listed by the council.

This year's internship and residency figures reverse the trend of the past several years, when unfilled positions were increasing. The report showed foreign medical school graduates in 1954-55 filling almost half of the vacancies not taken by American graduates, thus alleviating partly the demand for hospital staff appointees.

Another important change reported by the council was in requirements for residency training, which follows internship as the next step after medical school graduation.

Previously some programs offered specialist certification training which almost could be compared to allowing a medical student to receive his M.D. degree after "completing four successive years at the freshman level at four different medical schools." The new policy eliminates the possibility of taking specialty training in several separate programs and instead requires stricter continuity in an integrated training course.

The council's report noted that the average cash stipend paid to interns by hospitals affiliated with medical schools is \$87 a month compared to \$84 last year. Hospitals not affiliated with schools pay \$136 a month on the average, an increase of \$1 over last year. The report said figures indicate that the amount of stipend, as usual, has no effect on the prospective intern's choice of a hospital for training.

Federal hospitals, such as armed services or VA institutions, and local governmental hospitals offer 36.5 per cent of all available intern positions and have the highest rate of filled positions. Their rates range from 100 per cent for the Public Health Service, 99 per cent for Army hospitals, and 97 per cent for Navy. County and city-county hospitals have rates of between 93 and 96 per cent.



A NEW YALE MEDICAL SCHOOL BUILDING ON THE NEW HAVEN SKYLINE

This aerial view by C. T. Alburtus of the Yale News Bureau shows the "L" shape of the new building occupying the whole triangular block in the center of the photo. The main entrance of the Yale School of Medicine (with four columns) is at lower right. Part of the Memorial Unit of the Grace-New Haven Community Hospital can be seen at the left, across the street from the new Harkness building.

A new 11 story building named in memory of one of Yale University's greatest benefactors was formally opened at dedication ceremonies on October 7. The building is the Edward S. Harkness Memorial Hall, a huge residential center for Yale medical students. Costing \$2,750,000, the structure covers a whole block in the heart of the Yale-New Haven Medical Center. It is named after the late Edward S. Harkness, Yale Class of 1897, whose generous gifts to Yale for new buildings literally changed the face of the campus in the 1920's and 1930's.

The \$2,750,000 for the construction and equipping of Harkness Memorial Hall was given to Yale under a special grant of the Commonwealth Fund.

This Fund was founded in 1918 by Mrs. Stephen V. Harkness, Mr. Harkness' mother, "to do something for the welfare of mankind" particularly in terms of aiding medical education, research, and health services. Mr. Harkness himself served as president of the Fund until his death in 1940.

A red-brick, L-shaped building, Harkness Memorial Hall has two wings, one 11 stories high while the other wing is four stories. Connecting the two wings is a two-story structure housing a lounge and a dining hall.

There is dormitory space in the building for 266 medical students including rooms for both men and women students and special apartments for married

students. Harkness Memorial Hall is the first building at Yale constructed with some apartments specifically for married students.

But the new building is more than a dormitory. There are complete residential facilities for students including dining rooms, gymnasium, a game and music room, and snack bar. There is also a special apartment for a doctor and his family to live there as the resident faculty member. Donald P. Shedd, assistant professor of surgery, has been named to this post.

The residential plan is in line with the beliefs of the late Mr. Harkness that students should live and dine together. This plan has been in operation with regard to Yale undergraduates who live in the ten residential colleges built in large part through gifts from the Harkness family.

The new building is keyed to simplicity of design and easy maintenance. Except for the top floor, the ceilings of the new building are not plastered, but are concrete. The corridors have plastic composition walls, which require no papering or painting. The floorings in the rooms and corridors are vinyl asbestos placed right over the concrete.

Each of the single rooms has a wash basin and each floor in the main wing of the building has a special room with lavatory and shower facilities. A two-room apartment for bachelor faculty members is located on each floor of this section of the new building.

The resident faculty member's suite with a kitchen, a combination living room and dining room, and three bedrooms, is located on the main floor. Adjoining this is a guest suite for visiting lecturers and scientists.

Game, music and exercise rooms along with a snack bar where a television set will be installed are located on the basement level, which also contains storage and refrigeration space.

Joint Commission on Accreditation of Hospitals

The following statement is being published at the request of the AMA Committee to Review the Functions of the Joint Commission on Accreditation of Hospitals.

In June, 1955, the House of Delegates of the American Medical Association authorized the Speaker to appoint a committee ". . . to review

the functions of the Joint Commission on Accreditation of Hospitals . . ." and ". . . to make an independent study or survey and report its findings and recommendations to the House of Delegates at the next annual meeting. All physicians and hospitals are urged to pass on to this special committee any observations or suggestions concerning the functioning of the Joint Commission on Accreditation of Hospitals."

This Committee was appointed, and now, in undertaking the task assigned to it, is seeking to obtain from physicians and others their observations concerning the functioning of the Joint Commission. It is obviously impossible for the Committee to contact all physicians and others who may have observations or comments concerning the matter of hospital accreditation.

The Committee is interested especially in the following:

1. The general understanding by physicians of the functions of the Joint Commission.
2. Whether the method of appeal from an adverse ruling regarding accreditation is satisfactory.
3. The effect on the individual physician's hospital connections due to actions of the Joint Commission.
4. Whether any organizations not now represented should have official representation on the Joint Commission.
5. The effect of the Joint Commission's requirements concerning such matters as staff meetings.
6. The pros and cons of separating administrative and professional accreditation functions in the inspection of hospitals.
7. Constructive suggestions for improving the hospital accreditation program.

Any comments from individual members or State and county societies should be addressed to: W. C. Stover, M.D., chairman, Committee to Review Functions of Joint Commission on Accreditation of Hospitals, 535 North Dearborn Street, Chicago 10, Illinois.

These comments should reach the chairman not later than January 15, 1956.

W. C. Stover, M.D., chairman, Boonville, Indiana; John F. Burton, M.D., Oklahoma City, Oklahoma; Gerald D. Dorman, M.D., New York, New York; George F. Gsell, M.D., Wichita, Kansas; Eugene F. Hoffman, M.D., Los Angeles, California; T. C. Terrell, M.D., Fort Worth, Texas; George Unfug, M.D., Pueblo, Colorado.



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Series of Community Health Forums Planned by Hartford County Medical Association

A series of three community health forums will be sponsored by the Hartford County Medical Association in cooperation with the *Hartford Times* starting next January.

The first forum is scheduled for the evening of January 19 at the Horace Bushnell Memorial Hall, Hartford. Stewart P. Seigle, chairman of the Public Relations Committee of the association has announced that an extensive program of public information will be initiated soon to acquaint the public with the purpose of the series. Part of the program will comprise a newspaper poll to determine the leading health topics in which most people are interested. These returns will be used to select topics for the forums.

The forums will be open to the public free of charge and will comprise presentations by panels of physicians and question periods for audience participation. The forums will be similar to a highly successful series recently presented in the Greenwich and Stamford areas by local medical associations. John E. Burns and Norman M. Mann of Hartford are members of the committee planning the Hartford forums.

Fairfield County Association Indoctrinates New Members

The first program of indoctrination for new members of the Fairfield County Medical Association was held Wednesday evening, October 26, at the Stratfield Hotel, Bridgeport.

Sixteen new members of the association, accompanied by physicians who sponsored them, attended the dinner and meeting which marked the event. Officers representing the American Medical Association, The Connecticut State Medical Society and Fairfield County Medical Association described

medical association activities at national, state and county levels. D. Olan Meeker, Riverside, chairman of the Public Relations Committee, Fairfield County Medical Association, presided at the meeting and speakers were:

Oliver L. Stringfield, Stamford, president, Connecticut State Medical Society.

Thomas J. Danaher, Torrington, delegate, Connecticut State Medical Society to American Medical Association.

C. Louis Fincke, Stamford, chairman, Council of the State Medical Society.

Creighton Barker, executive secretary, State Medical Society.

Nathaniel B. Selleck, Danbury, president, Fairfield County Medical Association.

John D. Booth, Danbury, chairman, Committee on Medical Education and Licensure, State Medical Society.

John P. Gens, Norwalk, alternate councilor, Fairfield County Medical Association.

The activities of committees at the county level were discussed by: M. David Deren, Bridgeport, chairman, Board of Trustees; Isaac L. Harshbarger, Bridgeport, chairman, Board of Censors; J. Donald Corridon, South Norwalk, chairman, Committee on Medical Ethics and Department; Michael A. Dean, Bridgeport, secretary; Joseph C. Quatrano, Bridgeport, treasurer.

New members who attended the meeting included: Morris Jonathan Carl Allinson, Greenwich; Harry Abner Bradley, Jr., South Norwalk; William Francis Burke, Newton; William Harris Burke, Bridgeport; Gunnar Orville Eng, Stamford; Edward Joseph Gerety, Fairfield; James Mullet Grant, Bridgeport; James Joseph Griffith, Norwalk; Arthur M. Harrison, Stamford; Paul B. Kaunitz, Westport; Trent Laviano, Danbury; Thomas Dexter Lenci, Fairfield; Alice Ente Madwed, Bridgeport; Paul J. Ostriker, Stamford; Richard Charles Peterson, Stratford; William J. Rogers, Norwalk.

"March of Medicine" Series on Educational TV

The first series of medical television programs to be presented on a noncommercial educational TV station is scheduled for December 14 from the studios of WTTW, Chicago.

At that time a "March of Medicine" program, produced by Smith, Kline and French Laboratory in cooperation with the American Medical Association and the Chicago Medical Society will be screened at 9 P. M., C.S.T.

The December 14 telecast, entitled "We, the Mentally Ill," will be followed in subsequent weeks by nine other telecasts which have been presented over national networks.

Use of the new educational channel opens additional prospects for authentic health education through television.

Medical Society and CMS Exhibits at Fifteen Fairs

Exhibits on health protection and voluntary health insurance were sponsored by the State Medical Society and Connecticut Medical Service at fifteen Connecticut Fairs this fall in cooperation with the Woman's Auxiliary to the Society.

The exhibits were contained in portable carrying cases furnished to exhibit teams in seven counties.

Because of flood conditions, six fairs scheduled to be held in Litchfield County were cancelled. These were to have been managed by an exhibit team headed by Mrs. Andrew Orłowski, Torrington. Auxiliary members in charge of exhibit teams in other counties were Mrs. William A. Sinton, Danbury, Fairfield County; Mrs. Philip J. Moorad, New Britain, Hartford County; Mrs. Joseph Epstein, Portland, Middlesex County; Mrs. William S. Maurer, Willimantic, Windham County; Mrs. William Richards, Hamden, New Haven County; and Mrs. William Murray, New London, New London County.

The project was organized by Mrs. Robert Nespor, of Westport, public relations chairman of the Woman's Auxiliary. The exhibits were accompanied by quantities of health information pamphlets and many thousands of these were distributed to fairgoers.

Exhibits were displayed at the following fairs:

Fairfield County: Fairfield County 4-H Fair, Harmony Grange Fair.

Middlesex County: Middlesex County 4-H Fair, Chester Fair, Durham Fair.

Windham County: Windham County 4-H Fair, Brooklyn Fair, Woodstock Fair.

New London County: Hamburg Fair, Norwich Grange Fair.

Hartford County: Hartford County 4-H Fair, Wethersfield Grange, Union Agricultural Society Fair, Berlin Fair.

New Haven County: New Haven County 4-H Fair, North Haven Fair.

Report of Ad Hoc Committee on Flood Disaster Critique of The Connecticut Hospital Association

During the few weeks since its appointment your committee has met three times in addition to conferring by mail and telephone. Its deliberations relative to the experience of its members and the reports of others in connection with the floods of August and October have resulted in the following conclusions and recommendations as to disaster planning.

In general the disasters were met in a highly commendable manner and with favorable results in both hospital performance and coordination with other agencies. In most communities, however, this appears to have been in spite of, rather than because of the existence of, prearranged disaster organization at the community level. As a consequence it was done at the expense of considerable lost motion, duplication and misdirection of effort, disproportionate availability of personnel for certain activities and, in some instances, friction. Some of this might be avoided in the event of future emergencies if we can profit by the lessons of those under consideration.

Our observations seem to fall naturally in two classes: i.e., (a) those dealing specifically with hospitals in planning for the performance of their primary function; and (b) those pertaining to community organization and planning for disaster and the relation of hospitals to other agencies in such plans.

A. Observations relating to hospitals in planning for the care of patients in a disaster:

1. Each hospital should have a disaster plan on paper with which all employees are familiar, sufficiently detailed to serve as a key to coping efficiently with the emergency but not too detailed to allow for adjustment to the particular emergency to be met.

2. Hospital disaster plans should be built around two major objectives either of which may be met separately or in combination:

- (a) The need to function without the usual facilities (as during and following the recent floods).

- (b) The need to care for a greatly increased patient load (as in a bombing).

3. Each general hospital should equip itself in such a way as to be self sufficient under all conditions short of complete annihilation. More specifically this involves standby provision for all public utilities, such as, water, light and power, fuel, communication and maintenance of food and supply inventories sufficient to cope with greater than ordinary demands.

4. Hospitals have a right to expect provision for such extraordinary needs to be financed in some manner from tax or other public funds rather than from money realized from charges to patients.

B. Observations concerning community plans for disaster and the relation of hospitals to other agencies are based on the premises:

1. That whatever the community, regional or State planning for civil defense or civilian disaster the community hospital is regarded as a place of refuge by the populace and is forced into a prominent role in disaster relief work. The hospital is a security symbol in its area, even when no medical emergency exists.

2. That the organization of a hospital is by nature geared to the meeting of emergency situations; and hospital people are, by the nature of their every day contacts and experience, accustomed in considerable degree to the problems to be met in a disaster.

3. Sensations of futility, frustration and confusion associated with thoughts of possible atomic attack

have engendered apathy in local planning for any kind of disaster.

4. Providing two parallel sets of disaster organization is cumbersome, inefficient and promotes confusion.

5. In local communities there is inadequate understanding of the functions assigned at state and national level to the various disaster relief agencies (Civil Defense, Red Cross, Salvation Army, National Guard, Regular Army, State Health Department and Directors of Health, etc.)

C. Based on the foregoing observations the following recommendations are presented:

1. Hospitals should participate with other community leaders in planning for natural as well as war caused disasters.

2. Hospitals should be represented at the highest level in state, local and regional disaster planning.

3. In community organization for disaster relief there should be one authority and one overall plan regardless of the number of agencies or governmental units involved or whether the contemplated disaster is war caused or natural.

4. Community planning authorities (councils) should secure from the heads of the various agencies for disaster relief, or from higher levels, information as to the authorized scope of activity of each such agency, promulgate and utilize it insofar as it is applicable and take such other action as may seem necessary to clarify, facilitate and implement the local plan of organization.

5. Hospital makers of disaster plans should acquaint themselves with the plans for the area and community and integrate those of the hospital with them. They should also recognize, and where practicable provide for, the probability that they will be called on to perform functions not ordinarily required of hospitals (such as providing medical and surgical supplies to treatment units outside the hospital, providing food and shelter to evacuees, setting up immunization centers, etc.) in the event of circumstances rendering other provision for such services inoperative or insufficient.

Respectfully submitted,

Albert F. Dolloff, PH.D.

NEWS FROM WASHINGTON

Medical Research

If advance signs mean anything, the Eisenhower Administration next year can be expected to ask Congress for substantially more money for medical research, both direct research by scientists on the U. S. payroll and grants to others.

Currently the federal government is spending more money on medical research than at any time in history—almost \$98 million through the National Institutes of Health alone. In addition, other millions are being spent on medical research in the Department of Defense, Veterans Administration and other agencies. Much of it is difficult to isolate in the federal budget.

A special committee named by the National Science Foundation at the request of former Secretary Hobby has been at work for some time on an appraisal of HEW's medical research programs. Its report, due before the reconvening of Congress, should be valuable to both the administration and the appropriations committees.

Full Medical Care Urged For Six Month Reservists

Medical and dental officer requirements of the Army and Navy will increase materially if Secretary of Defense Charles E. Wilson implements new recommendations of National Security Training Commission. Its report urges that 6 month trainees in military's new reserve program receive hospitalization, medical, surgical and dental care "in the same manner it is presently furnished for the armed forces in general." The Commission goes further, recommending that recruits be retained beyond their training period—with their consent—for continuation of medical or dental care of illness or injuries originating while they are in uniform.

Program Now Under Way

Marine Corps, whose medical services are performed by Navy, and Army accepted their first six month trainees last week. Army started out with 1,100, will induct at least 4,000 more by end of this year and plans to train 100,000 in 1956. Marine

Corps quota is 5,500 through June, 1956. With military medical departments facing high attrition rates next year, in the matter of doctors fulfilling their service obligations, it is apparent that replacement figures must be revised upward if trainees are to receive health care benefits identical to those enjoyed by longer term personnel.

Draft Callup Announced

Selective Service has received Army requisition for 297 physicians and 119 dentists. It was first callup under doctor draft law since last November when 1,275 physicians and 459 dentists were ordered for apportionment among Army, Navy and Air Force. No further callup is anticipated before next April at the earliest. Army wants the 119 dentists on active duty in January, a goal it is unlikely to attain. February is target month for commissioning—or induction—of the 297 physicians. They will start active duty in April.

As for Army's requisition for 297 physicians, Selective Service is asking States for up to date information on total numbers in Priorities I and II and totals in III who were born on or after January 1, 1925. Thus it appears intention is to induct no Priority III physicians over age 30. Every 30 days SS headquarters receives statistical data on doctor draft registrants, covering age groupings and classifications, but it has so little confidence in their accuracy that special requests are made for figures prior to a military callup.

Residency-Deferment Plan

In connection with residency-deferment plan now in first year of operation, teaching hospitals now making arrangements for residency appointment next July should take warning. While some 500 draft-vulnerable young doctors are to receive deferment to begin residencies next year, under Defense Department and Selective Service dispensation, this is only a fraction of total which hospitals will need. And since military medical replacements will run at least twice as high in 1956-57, in comparison with 1955-56, draft deferment for purpose of starting, continuing or competing residency training is going to be much harder to get.

Between next July and June 30, 1957, military needs for physicians "will be of such magnitude as to require active duty of all interns and residents who have not satisfied their military liability, and perhaps some liable physicians of priority III who are older and who may be established in practice." This warning, from the National Advisory Committee to Selective Service, adds that "it will not be possible to support deferment for any current intern for residency training except those included in the Department of Defense's Residency Consideration Program and perhaps some in exceptional situations necessary to the national health, safety or interest"

Dr. Berry Sees Doctor Draft Amendment Hurting Procurement

The Defense Department's Assistant Secretary in charge of health and medical affairs wants the doctor-troop ratio raised, and he warns that one of the amendments to the doctor draft extension passed last summer may put a serious crimp in procurement of older physicians. These were the highlights of Dr. Frank B. Berry's annual report to the Secretary of Defense for the period ending June 30, 1955.

Dr. Berry feels that in some areas the ratio has been cut too sharply since the order of more than two years ago from Secretary Wilson for an overall reduction to 3.0 per 1,000 troops. He is planning to recommend a return to a figure somewhere near where it was before May, 1953, or 3.4.

In this year's doctor draft amendments, he noted that Congress provided that any person 35 years or older who had applied for a commission in the armed forces in a medical, dental or allied specialist category and who had been rejected on the sole grounds of physical disqualification would be relieved of any further liability under the act. This, he said, "may seriously affect the ability of the three services to obtain the required number of older Priority III physicians" during the next two fiscal years. Estimates by the various services of losses from the remaining pool of Priority III's range from 10 to 75 per cent. He adds: "It has not yet been possible to determine the full impact of this amendment." Estimated reduction in medical officers for fiscal 1955: 1,108.

Army Employs Civilian Physicians

The Army has received authority from the Civil Service Commission to employ civilian physicians at dispensaries, infirmaries, outpatient clinics, and laboratories at the top step of each respective CSC grade. For example, effective immediately, civilian physicians may receive beginning salaries of from \$7,465 to \$11,395 per annum.

Although increasing numbers of civilian doctors are joining Army medical installations throughout the country, openings exist in practically every locality. On June 30, the Army was employing more than 20 per cent more civilian physicians than it was six months earlier. Those interested in securing employment with the Army, and who have a license to practice medicine in any of the States or the District of Columbia, should communicate with the personnel officer at the nearest Army installation of their choice.

Medical Care Costs Rises, Now No. 2 in Price Index

Labor Department consumer price index for September, 1955 reveals medical care second only to rent. Their index figures, respectively, are 128.2 and 130.5 (1947-49 period = 100). In other words, charges for medical and dental services, and hospitalization, have risen 28.2 per cent since pre-Korea. For random comparisons, food prices have gone up 11.6 per cent, apparel 4.6, transportation 25.3 and all consumer commodities and services combined, 14.9 per cent.

Legion Sticks to Guns on Nonservice Cases

Summary of actions taken by American Legion at national convention in Miami last month has these highlights: Policy reaffirmed in support of VA medical care and hospitalization for nonservice connected cases; Congressional legislation authorizing recognition of chiropractic by VA's medical department rejected; extension of time for presumptive service connection of all physical and mental disabilities rejected.

Government Launches Drive on Illegal Sale of Amphetamines

The federal government has launched a campaign against the illegal sale of amphetamines with initial charges against 42 persons in six States. They are

described as operators of cafes, service stations, and drug stores, and are accused of selling stimulant drugs without prescriptions to truck drivers. A joint announcement of the drive was made by Attorney General Brownell and Secretary Folsom of the Department of Health, Education and Welfare.

The Brownell-Folsom statement quoted Food and Drug Commissioner George Larrick: "These amphetamine drugs have important medical uses and are of value when properly dispensed on prescrip-

tion and used under medical supervision, but they are extremely dangerous when sold and used by persons unfamiliar with their effects. . . . The improper use of these drugs is by no means confined to truck drivers. They are also associated with problems of juvenile delinquency and crime."

The arrests marked a year long investigation by FDA agents, who posed as truck drivers and employed a truck-trailer borrowed from the Army and painted to look like a commercial truck.



State Medical Society Supervises Educational TV Program

Dr. Burdette J. Buck, Hartford (right) explains to Robert Wakeley, moderator, the importance of examinations by family physicians in the early detection of diabetes during a telecast on Diabetes Week November 3 from the studios of WKNB-TV (Channel 30). Dr. Samuel Donner, Hartford (left) has just completed a discussion of modern methods of diabetes control.

The photo was taken shortly after the 15-minute afternoon telecast went on the air as a public service feature in cooperation with the Connecticut State Medical Society, the Hartford County Medical Association and the Connecticut TV Committee for TV Health Education. The script and program outline were prepared by James G. Burch, public relations director for the State Medical Society, as one of a series entitled "Accent on Living."

The Connecticut Regional Blood Program

Commencing with this issue, the JOURNAL will publish the monthly activity report for the Connecticut Blood Program. We believe this will be of interest to physicians in the State so they may be informed of the magnitude of the services the Bank gives to the people of Connecticut.

The Bank commenced operations in June, 1950 and has, since that time, delivered to the hospitals of the State approximately 400,000 pints of blood. This blood is collected through recruitment by local Red Cross chapters by three blood mobile teams continuously in operation in all parts of the State. A physician is present at all mobile unit operations to insure the safety of the donor and, by screening donations, the safety of the recipient.

After collection, blood is processed at the Center in Hartford and distributed weekly on an equal basis to all hospitals.

The success of this volunteer program depends on its support by the people of Connecticut, among whom are the physicians who are more aware than any other group of the need for blood.

	JULY 1 TO OCTOBER	
	OCTOBER 1955	31, 1955, INCLUSIVE
DONORS		
Donors accepted	6,900	27,598
Donors rejected	1,025	4,192
Donors registered	7,925	31,790
BLOOD ISSUED TO HOSPITALS		
	PINTS	
To Connecticut hospitals from center	5,710	21,950
Blood collected by hospitals.....	742	3,818
To out of state hospitals.....	55	627
	6,507	26,395
PROCESSING AT CENTER		
Processed into fresh frozen plasma, packed cells and liquid plasma.....	804	3,741
Discarded—unfit and broken.....	30	121
Grand Total—distribution of blood....	7,341	30,257
Blood returned to center for process- ing into plasma and fractions.....	562	2,727

Better Medical Journals

The recent State Medical Journal Conference sponsored by the State Medical Journal Advertising Bureau and the American Medical Association brought to the attention of the editors and business managers who attended the great advances in

methods of modern communication attributed to radio and television. Mr. O. M. Forkert of Chicago, an expert in the field of journal format and makeup, pointed out the opportunity which medical journals have to lead the way in bringing to the profession the advantages of attractive journals, easily read and well arranged. What must never be forgotten, however, is the fact that no journal is any better than the copy it contains. In the last analysis the appeal to the reader and to the advertiser alike is the result of the labors of the editors. State journal editors are becoming more aware of the importance of their publications through such conferences as the one recently held in Chicago.

The volume of business handled by the State Journal Advertising Bureau for the first time in its history has reached the million dollar mark. This in itself is an invaluable aid to the State journals in producing better publications.

In the evaluation of the 33 individual journals made by Mr. Forkert, Connecticut may be justly proud of its rating among the top few. Ways and means of improvement were pointed out and no one was left with a sense of having attained the maximum in accomplishment.

The key address at the opening of the conference was made by the managing editor of the JOURNAL.

Attending Physicians Determine Hospital Costs

“The total cost of direct service to hospital patients is largely determined by the attending physicians,” according to Bedford W. Bird, assistant area administrator, United Mine Workers’ Welfare and Retirement Fund, Knoxville, Tennessee. In an article on the principles of payment for hospital care in a recent issue of the official journal of the American Association of Hospital Accountants, Mr. Bird had this to say: “The task of many hospital administrators and/or hospital staffs, is to obtain cooperation from the medical profession in preparing adequate records promptly, ordering only those services which are necessary and discharging the patient at the earliest possible time. Recognition by the physician of the economic factors involved in their use of hospital facilities and consideration of these factors, together with the medical needs of the patient, will do much to help reduce the cost of hospital care to the patient and the community.”

FROM OUR EXCHANGES

Feltman and Kosel of Passaic General Hospital, Passaic, New Jersey (*Science*, 122:3169, pp. 360-361) have assumed that, because McKay and Black found that factors influencing the integrity and structure of tooth enamel are effective only during the calcification period, any beneficial effects from fluorides would be derived only while the teeth are in developmental stages when the matrix is being formed and the enamel is undergoing calcification or maturation. They conducted a long range study giving fluorides to expectant mothers during pregnancy and also to the child until permanent tooth calcification has occurred.

The results of the study to date indicate that the fetal blood level can be increased by supplementation either in tablets or water but because there is no known normal or optimum concentration it is difficult to assess the importance of these findings. Except for an increased fluoride concentration in both the cord blood and the placental tissue of the study cases, no correlation was demonstrated.

* * * *

According to Hill ("Diseases of the Terminal Portion of the Colon," *Jour. Indiana State Med. Soc.*, 48:8, pp. 857-863) twelve per cent of all malignant conditions of the human body originate in the anus, rectum and lower part of the sigmoid colon. In a study of 8,502 consecutive individuals admitted to the Garfield Memorial Hospital Detection Clinic by Raad (*Med. Ann. Dist. Col.*, XXIV:8, pp. 391-393) one hundred and thirty-nine had polyps, a prevalence rate of 1.63 per cent.

It will at once be noted that the two authors are not dealing with the same thing. Dr. Hill is basing his figure on malignant conditions and Dr. Raad is discussing the prevalence of polyps in the normal adult population. A careful reading of the two articles suggests that the authors are in essential agreement as to the incidence and treatment of the polyps frequently found in the lower bowel.

Both Dr. Hill and Dr. Raad conclude that polyps of the lower colon are cancerous or precancerous lesions; and that all should be treated on that basis. Detection and eradication, by one method or another, is urged upon the medical profession. That

such efforts play a paramount role in the field of cancer prevention is a conclusion that both authors stress.

* * * *

Regional enteritis is a disease that is occasionally met with in general practice. Bargaen's discussion of the disease is based on a study of 600 cases admitted to the Mayo Clinic between the years 1912 and 1949 (*Wisc. Med. Jour.*, 54:8, pp. 367-374).

Regional enteritis is commonly a disease of young adults (it may occur at any age); and is typified clinically by abdominal cramps, diarrhea, fever, loss of weight, anemia, and perianal abscesses and fistula. Hemorrhage of varying severity may occur but is less common than the symptoms already mentioned. Allergy has been suggested as a cause; and so have virus infections. The facts are that the pathogenesis of this disease is not clear.

Dr. Bargaen does not regard regional enteritis as primarily a surgical condition. The problems of management of this situation are difficult. The use of sulfonamides such as phthalylsulfathiazole (Sulfathaladine) and salicylazosulfapyridine (Azulfidine) is advocated along with a high protein diet, extra vitamins, and attention to the fluid balance and adequate nourishment. A helpful therapeutic measure in the author's experience has been roentgen therapy.

As already mentioned, the management of this disease is difficult. Regional enteritis tends to be relentlessly progressive. The removal of a segment of the intestines frequently does not accomplish the desired results. A few patients under treatment do well. In many patients the intestinal inflammatory process marches on inexorably. The author's final conclusion is that roentgen therapy is not the last word in the treatment of regional enteritis; but it is a good second best, if not the best, from the standpoint of present day treatment.

* * * *

Shellito and Stofer in a discussion of "The Surgical Treatment of Gastritis" feel that chronic hypertrophic gastritis, when seen through the gastroscope, is a lesion to be watched closely and to be considered as a clinical precancerous lesion until proved

otherwise (*Jour. Kansas Med. Soc.*, LVI:8, pp. 423-429). The authors are of the opinion that chronic hypertrophic gastritis is a continuous cytologic process. It is progressive from a simple inflammatory or exudative gastritis through hypertrophic gastritis or hyperplasia, and is followed by atrophic gastritis and finally by malignancy. If an ulcer appears, or a space filling defect, either by x-ray or gastroscopic means, the patient should be explored as the only sure way to determine the malignancy or nonmalignancy of a lesion in the stomach.

* * * *

Hiatus hernia and peptic esophagitis is not a rare condition. Kahn states that the frequency of hiatus hernia vary in frequency in different gastrointestinal series; from 3 per cent to 12 per cent of all G.I. series will demonstrate hiatal hernias (*Jour. Ark. Med. Soc.*, LII:3, pp. 62-68).

The diagnosis of hiatus hernia often presents difficulties. While it is true that many hiatus hernias present the classical picture of dyspepsia on lying down with relief on standing, it still must be remembered that hiatus hernia is a great imitator and may simulate many serious upper abdominal and thoracic diseases.

Esophagitis as a complication of hiatus hernia is a controversial subject both as to etiology and treatment. The author believes that the bulk of the evidence favors peptic regurgitation due to the loss of the so-called cardiac valve as the causative agent. Dr. Kahn confesses that the perfect surgical therapeutics for this condition is yet to be found.

* * * *

"Carcinoma of the Stomach—The Need for Earlier Diagnosis and More Adequate Therapy" is the subject of an informative analysis by Ochsner and Blalock (*Jour. Fla. Med. Assoc.*, XLII:2, pp. 99-107). The authors state that in spite of the fact that cancer is a common lesion in men the results from treatment are bad. They feel that it is deplorable, in a lesion about which we know so much and that occurs so frequently as cancer of the stomach, that we have not been able to accomplish more by way of a cure. They place the chief blame on the fact that there is so often a long delay from the

onset of the first symptoms until definitive therapy is instituted and that other lesions are diagnosed when gastric cancer should be suspected. In their own series there was a delay of 8.4 months. If lesions of the stomach which are definitely precancerous lesions, such as polypi, gastric ulcers, gastric anacidity, particularly associated with pernicious anemia and gastritis, were looked upon with suspicion and in many instances subject to resection, early malignant gastric lesions will be treated at a time when the lesion is still limited to the stomach. Minimal gastric symptoms when they occur in men past 40 years and are accompanied by a loss of weight of more than 10 lbs., even when the roentgen evidence and the gastroscopy evidence is normal, should be given the advantage of abdominal exploration to determine the presence or absence of a malignant lesion in the stomach.

* * * *

Powell in "An Evaluation of Results in 71 Transorbital Lobotomy Cases Five Years Postoperative" discovers that these cases have actually cost the patient and the institution more as compared with conservative methods of treatment, taking into consideration surgical expenses and the fact that fewer of these patients were able to leave the hospital as a result of the procedure (*W. Va. Med. Jour.*, 51:9, pp. 284-290).

It is not denied that this type of operation may produce good results in carefully selected cases. The decision to do a transorbital lobotomy should not be made lightly. It is apparent that there is a crucial period in the course of the disease when the operation should be performed and that is when the stage of chronicity has become such that the procedure is justified, but before deterioration has progressed to the point where the operation would be of no benefit.

No deaths occurred in the transorbital lobotomy group as a result of the first procedure, however two deaths occurred as a result of the second operation. There were 59 cases of schizophrenia in the group reported by Dr. Powell. Dr. Sadler is quoted as writing "Let us face the facts. The lobotomy only exchanges one defect for another and even more permanent one."

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Norman J. Barker, Collinsville

President-Elect, Mrs. E. Roland Hill, Mystic

First Vice-President, Mrs. Charles Murray Gratz, Cos Cob

Second Vice-President, Mrs. Morton Arnold, Windham Center

Recording Secretary, Mrs. Charles Culotta, Hamden

Corresponding Secretary, Mrs. James E. Stretch, Simsbury

Treasurer, Mrs. Joseph Cutler Woodward, South Lyme

The Twelfth Annual Conference of State Presidents, Presidents-Elect and National Committee Chairmen was held in Chicago, November 1 to 3. Sessions on the first two days were held at the Drake Hotel. On Thursday, November 3, members went to AMA headquarters where a program of films, tour of the building and luncheon was given them.

"Active Leadership in Community Health," the theme of the national president for 1955-56, highlighted the panel presentations. The national chairmen served as moderators and the State presidents or presidents-elect as panel participants. There were questions and answers following the panel presentations. Elmer L. Hess, president of the American Medical Association, was one of the guest speakers during the Conference.

There were two strictly social affairs arranged, a "get-together" the first evening of the Conference and a "dutch treat" dinner the second evening.

FAIRFIELD

Mrs. John Gens, chairman of Public Relations, is working to establish a G.E.M.S. program with the Boy Scouts. The initial venture will be used in New Canaan.

Mrs. George Geanuracos of Bridgeport and Mrs. Halsey Bullen of Stamford, chairmen of Ways and Means, ran a December Ball at the Shorehaven Golf Club in East Norwalk on December 3. The proceeds went to the Nurses Scholarship.

At the fall meeting on November 14, Mr. Arnold Olson, executive secretary for the Fairfield County Medical Association, was the guest speaker. His subject was: "The Reasons for and Importance of the Woman's Auxiliary."

HARTFORD

The annual rummage sale for the benefit of the Scholarship Fund netted \$800. At present scholarships are going to eleven nursing and medical stu-

dents. The chairman of the sale was Mrs. Francis D. Bowen.

Another project under way is the Medi-Capers Dance which will be held Saturday, January 21, at the Hartford Club. The proceeds from this event will be added to the Scholarship Fund. Mrs. Edmund Beizer is chairman of the dance.

LITCHFIELD

The 10th Anniversary luncheon of the Auxiliary was held on November 4 at Carters in Litchfield. Mrs. Nicholas Samponaro, chairman of Hospitality, made the arrangements. The following past presidents who attended were: Mesdames Frank Polito, John Elliott, Royal Meyers, Daniel Samson and Winfield Wight. Mrs. Meyers gave a history of the organization and the occasion was celebrated with a large anniversary cake.

The fall board and semi-annual meeting was held in the library following the luncheon. Mrs. Niel Russo of Thomaston was introduced as a new member, bringing the membership to 58. Mrs. James McKenna, chairman of American Medical Education Foundation Committee, presented plans for a fashion show of furs and card party to be held in Torrington in January. Christmas gifts for patients in Fairfield Hospital were collected and other members are urged to get their gifts to Mrs. Jeffrey Ferris of New Milford, Mental Health chairman, or to Mrs. Royal Meyers of Watertown, secretary. Members were reminded to send their Christmas subscriptions for *Today's Health* to Mrs. Frank Ursone in Norfolk.

MIDDLESEX

The November meeting was devoted to the County Auxiliary's primary project this year: the American Medical Education Foundation. A letter circulated among the membership by the chairman, Mrs. Mark Thumim, asked for a specific minimum contribution. To date contributions amount to \$155.

Harry Knight, formerly chairman of the Advisory Committee to the Woman's Auxiliary to the Connecticut State Medical Society and present chairman of Public Relations for Middlesex County, spoke to the members about the background, needs and value of the Foundation. Following his talk the chairman showed the AMA film, "Danger at the Source." The meeting was held in the home of Mrs. Harry Knight, with Mrs. Richard Grant and Mrs. Americus Longo in charge of hospitality.

The winter meeting will be held in January. Plans are being made to have this a social evening with a hobby show as the feature.

Dental Caries Not Due to Acids

A new and revolutionary theory of dental caries has been announced in the October issue of *The New York State Dental Journal*. Dr. Albert Schatz, director of research and co-discoverer of streptomycin, together with Dr. Joseph J. Martin, research professor at the National Agricultural College, Doylestown, Pennsylvania, have turned the prevailing lactic acid theory upside down. They claim that acids, long believed to cause dental caries, may actually help prevent tooth decay.

For almost a century, most people have tried to blame dental caries on lactobacilli and other bacteria which ferment sugars. The fermentation acids formed were supposed to dissolve the mineral matter in the hard outer enamel surface of teeth and thus start the decay process. But the acid theory has never been conclusively proved, and efforts to prevent caries by neutralizing or eliminating fermentation acids from the mouth have not been very successful.

Drs. Schatz and Martin therefore decided to look elsewhere for the cause of tooth decay. Since teeth contain both mineral and organic matter, they concentrated on the organic component. In this work they were guided by the discoveries of Dr. Charles F. Bodecker, internationally known professor emeritus of dental histology at Columbia University. From microscopic studies of decayed teeth which began in 1906, Dr. Bodecker ingeniously concluded that the bacterial destruction of tooth organic matter, rather than acid action on tooth minerals,

must be important in caries. But the failure of dental bacteriologists to isolate such bacteria was unfortunately considered as proof that they did not exist, and so Dr. Bodecker's theory was not taken seriously by many workers.

But Drs. Schatz and Martin have recently isolated microbes from the mouth which fit the picture of tooth decay revealed by Dr. Bodecker's histological experiments. Furthermore the destructive action of these newly discovered bacteria is believed to be held in check by lactobacilli and other acid-producing bacteria in the mouth. Thus it seems that one of nature's defenses against caries may perhaps have been mistaken for the cause of tooth decay.

According to the new theory, there is a possibility that the dentifrices in current use may actually increase rather than prevent caries. Dentifrices are generally designed to neutralize or prevent acid formation in the mouth. But the kind of bacteria which Drs. Schatz and Martin believe cause tooth decay appear to be more active under alkaline conditions and to be curtailed by acid. These investigators therefore suspect that dentifrices which alkalize acids or inhibit lactobacilli in the mouth may possibly do more harm than good.

The research from which this new theory evolved was supported by a grant from the National Institute of Dental Research of the United States Public Health Service, which is encouraging all efforts to solve the important riddle of dental caries.

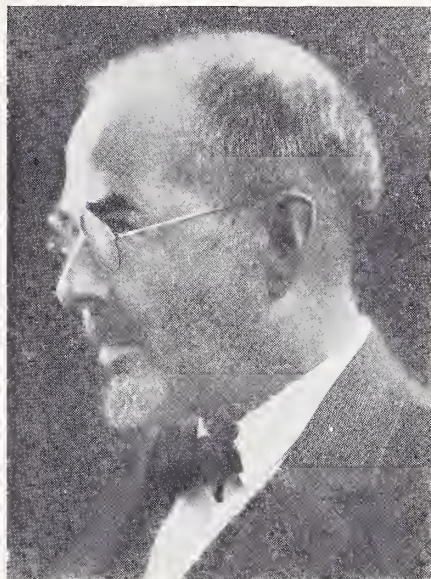
Labeling Ruling Issued on Aspirin to Protect Children

To protect children from accidental poisoning from overdoses of aspirin and other salicylate drugs, Food and Drug Administration is calling on manufacturers to use conspicuous package warnings that these preparations should be kept out of the reach of children. The recommended statements are: "Warning—Keep Out of the Reach of Children," or "Warning—Keep This and All Medications Out of the Reach of Children." Instead of dosage instructions for children under three years of age, FDA recommends this statement on the label: "For Children Under 3 Years of Age, Consult Physician."

OBITUARIES

Charles P. Botsford, M.D.

1870 - 1955



When Dr. Charles P. Botsford died while driving through one of Hartford's parks on September 6, 1955, a man passed from the scene of public health who was closely identified with the major developments in that field during the bacteriological era, 1875-1920.

Born in Cromwell on September 22, 1870, the son of Isaac and Emma Ann Penfield Botsford, he attended Berlin and Middletown schools before graduating from Yale Medical School in 1894. After interning two years at the Hartford Hospital, he set up practice in Hartford in 1897. Very early he was identified with official health activities of the city, serving first as medical inspector, and then in 1907 he became Hartford's first full time director of health (health officer).

He served in this capacity until his retirement on October 1, 1935. He was the second full time director of health in the State. During his term of office he was a devoted public servant, setting up a unique method of handling vital records, developing effective programs in sanitation, control of communicable disease, establishing modern methods of hospitalizing infectious disease. He was particularly interested in developing safer ways of feeding infants to reduce the havoc wrought by summer diarrhea.

As a man he was of a retiring nature, always pleasant, a student in many fields, well read and carrying with him a veritable storehouse of information about the flora and fauna of Connecticut.

Married in 1902 to the late Marion G. Chapman, daughter of the late Mr. and Mrs. Robert Chapman of Old Saybrook, he had no children and leaves no survivors.

He was a member of the Hartford Medical Society, the Hartford County Medical Association, the American Medical Association, the American Public Health Association and the Connecticut Public Health Association. He was especially honored by the American Public Health Association.

His influence on the medical and public health history of Hartford will become more firmly established as the years go by.

Alfred L. Burgdorf, M.D.

Eugene Funk Meschter, M.D.

1877 - 1955



Eugene Funk Meschter died in the Stamford Hospital at Stamford, Connecticut on September 1, 1955 at the age of 78 after a lingering illness.

Dr. Meschter, a native of East Greenville, Pennsylvania, received his M.D. degree in 1898 from the University of Pennsylvania after which he served a year's internship at the Samaritan Hospital in Philadelphia, Pennsylvania. He spent the first several years of his professional career in private practice before accepting an appointment as medical examiner for the Pennsylvania Railroad. In this capacity he assisted in developing the original first aid safety package carried on the Pennsylvania Railroad trains. In 1929 he joined the Stamford plant of the Yale & Towne Manufacturing Company as plant physician where he remained until his retirement in 1952.

Aside from his intense interest in industrial medicine Dr. Meschter was very active in Stamford Hospital and civic affairs. He was a member of the American, Connecticut, Fairfield County and Stamford Medical Associations, having served alternately as secretary and president of the latter organization. From 1938 to 1948 he was chairman of the Section of Industrial Medicine of the State Medical Society, was a member of its committee on industrial health and was chairman of a committee to study the medical aspects of the Connecticut compensation laws.

From 1940 to 1946 he was a member of the House of Delegates of the Connecticut State Medical Society. As one of the early members of the American Association of Industrial Physicians, he was appointed a Fellow in the organization in 1938 and an honorary member in 1940.

Locally his hospital connections comprised membership on the consulting staff of St. Joseph's Hospital, and on the associate staff of the Stamford Hospital until his retirement in 1952 when he was placed on the courtesy staff of the latter institution. His activities in community affairs were varied and forceful. He was one of the original directors of the Stamford Rehabilitation Center, a past president of the Stamford Kiwanis Club and had served on the Boy Scout Council, the Community Council and the Community Chest. Dr. Meschter was a member of the First Methodist Church in Stamford and of the Olean, New York, Lodge of Masons. His wife, the former Ernestine Anne Kaiser, died four years ago.

David P. McGourty, M.D.

Harry C. Clifton, M.D.

1879 - 1955

Dr. Harry Coltman Clifton was born in Lancasterville, Montgomery County, Pennsylvania, November 11, 1879. His early education was acquired in the public schools and the Central Manual Training High School of Philadelphia. He graduated from the University of Pennsylvania Medical School in 1901. While a student at the University of Pennsylvania he became a charter member of Phi Sigma Kappa fraternity, Alpha Mu Pi Omega medical fraternity and participated in the activities of the Mask and Whig Club.

After graduating from medical school he acted as assistant physician at the State Hospital at Norristown, Pennsylvania and later served as resident physician at the Lankenau Hospital from 1902 until 1904. During his residency he trained under the late John B. Deaver of Philadelphia. Dr. Deaver recognized his early ability and invited him to remain in Philadelphia as his surgical associate. But a strong independent spirit moved him to Hartford where he entered practice in 1904.

Dr. Clifton practiced surgery in Hartford until his retirement in 1951. During his early years of practice he became president of The Health Board, city physician and chief physician and surgeon at the City Hospital, later the McCook Memorial Hospital. He was attending surgeon at St. Francis Hospital for many years and also consulting surgeon to Willimantic, New Britain, Rockville, Bristol and Manchester Hospitals, as well as the Institute of Living, Veteran's Hospital, Cedarcrest and Shelton Sanitaria. His professional achievements included membership in The John B. Deaver Surgical Society, American College of Surgeons, founders group of the American Board of Surgery, The New England Surgical Society, Hartford Medical Society, Connecticut State Medical Society and the AMA. At the last annual meeting of the Connecticut State Medical Society held in Stratford in April, 1955 he was awarded the 50 year pin, in absentia.

Dr. Clifton's keen diagnostic sense, excellent technical ability and meticulous attention to pre- and postoperative details made him an outstanding surgeon in this community. His calm reassuring gentlemanly manner won the respect and admiration

of his countless patients. To his friends and associates he exhibited a sharp wit and a warm sense of humor.

Dr. Clifton succumbed to a long illness at his home in Bloomfield on May 24. He is survived by his widow, Mrs. Eleanor Brockman Clifton.

John T. Winters, M.D.

George Gifford Fawcett, M.D.

1884 - 1955



In the death of Dr. George Gifford Fawcett, 71, retired director of surgery and chief of staff of the Norwalk Hospital, the medical profession and Fairfield county have lost an outstanding leader and citizen and a surgeon whom patients will long remember gratefully.

He died September 6, 1955 in the Norwalk Hospital where he had been a patient since August 22, when a brave tired heart stopped functioning as it had threatened to since 1948 when he was forced to retire from active practice and resigned as chief of the hospital staff.

He is survived by his wife, Mrs. Gertrude Lang Fawcett; a son, George Gifford Fawcett, Jr. of New York City; two daughters, Mrs. James G. Leonard of New York City and Mrs. George Manning James of Ormond Beach, Florida; a sister, Mrs. Joseph Adams of Portland, Oregon and eight grandchildren.

Dr. Fawcett was born on a farm in Cedar Rapids, Iowa in 1884, son of William Hamilton and Margaret Porter Fawcett. At an early age he moved

with his family to Boise, Idaho, where he received his elementary schooling. He attended preparatory schools, and was graduated from the University of Idaho with a B.S. degree. During summer vacations he was employed by the U. S. Forestry Service.

Dr. Fawcett attended University of Chicago Medical School, and at the end of his second year was recommended as the most promising student in the school to the famous thyroid specialist, Dr. John Rogers of New York City. Under Dr. Rogers' supervision he did experimental surgical work in Loomis Laboratory and completed his medical education at Cornell University, receiving his M.D. degree in 1915. He served his internship in St. Francis Hospital, New York.

As an intern in 1916 he married Gertrude Lang of Hornell, New York, who survives him, and started practice in Norwalk in 1917. He took over the practice of the late Dr. Jean J. DuMortier, who died several months previously.

Dr. Fawcett was active for many years on the Norwalk Hospital staff, serving as director of surgery and chief of the staff for a long period. One of the prime movers in the hospital's expansion program, he was instrumental in establishing and maintaining standards, making it one of the best equipped and best run hospitals in the nation.

He was a former vice-president of the Connecticut State Medical Society and a former president of the Norwalk Medical Association. He was also active in the Fairfield County, and American Medical Associations. For several years Dr. Fawcett was consulting surgeon at the old Fitch Home for Soldiers in Noroton and volunteered his services as medical attendant for the Norwalk Day Nursery. He was the surgeon for the old Hillside School and was a consultant for the Thomas School.

Dr. Fawcett was chief medical examiner for Selective Service Board 26B in World War II and was awarded the Legion of Merit for his services. He was a member of the Executive Committee of the Women's Field Army of the American Society for the Control of Cancer and was a former vice-president of the Norwalk Tuberculosis and Health Association. Dr. Fawcett served as a director of the Norwalk YMCA. He was a Fellow of the American College of Surgeons and was a member of the State Committee on Industrial Health.

Dr. Fawcett contributed many articles to the *Journal of the American Medical Association* and the *CONNECTICUT STATE MEDICAL JOURNAL*. On two

occasions he attended medical conferences at the Mayo Clinic, where he also did advanced study. Dr. Fawcett was also an indefatigable worker in civic enterprises. He served as a Republican member of the Board of Education for 20 years, was chairman for 15 years.

He was a member of Old Well Lodge, A. F. & A. M., Independent Order of Odd Fellows and a former member of the Kiwanis Club. He formerly belonged to the Norwalk Country Club, of which he was a president, Wee Burn Club, Fairfield Hunt Club and the Cornell Club of New York. He was also a member of Phi Delta Theta and Nu Sigma Nu fraternities.

He was a true physician and surgeon of the old school and seldom has a better pair of hands worked for humanity.

Clifford W. Mills, M.D.

Clarence G. Thompson, M.D.

1889 - 1955

Norwich lost a highly regarded citizen and the State a veteran public health official with the passing of Dr. Clarence G. Thompson of metastatic malignancy.

Dr. Thompson took his premedical work at Fordham University and graduated from New York Homeopathic Medical School and Flower Hospital in 1919. He interned at Flower Hospital and Old Metropolitan Hospital in New York City, and the W. W. Backus Hospital, Norwich, Connecticut. He started practice in Norwich in 1921 and continued until illness forced his retirement.

Dr. Thompson served the City of Norwich in various public health capacities over a long period of years, and was health officer in Norwich on several occasions, having held that office for years under the old form of government and was named director of public health following consolidation in 1952. He had also served as health officer for the Towns of Preston and Ledyard for a long period of time. He was a pioneer member of the New London County Chapter of the Infantile Paralysis Foundation, having been vice-chairman up to the time of his death.

Dr. Thompson was a member of the American Public Health Association, the American Medical Association, the Connecticut State Medical Society, the New London County Medical Association and the Norwich Medical Society. He belonged to the

New England Pediatric Society and the Hezekiah Beardsley Club and was associated with the pediatric staff of the W. W. Backus Hospital.

Beside his wife he leaves a daughter, Mrs. Henry Morgan Lozier of Hamden, Connecticut, and three grand-children: Betsy Morgan Lozier, Anne Boro-dell Lozier, and Peter Way Thompson Lozier.

Dr. Thompson was not afraid to die, as Sir Francis Bacon has written: "It is as natural to die as to be born. He that dies in an earnest pursuit is like one that is wounded in hot blood, who for the time scarce feels the hurt; and therefore, a doth avert the dolours of Death, but above all where man hath obtained worthy ends and expectations Death hath openeth the gate to good fame and extinguisheth envie."

Clifford E. Wilson, M.D.

Bruce J. Coyle, M.D.

1890 - 1955



Dr. Bruce J. Coyle, aged 65 years, died of a coronary occlusion at his home on August 5. He was born in Windsor Locks on May 19, 1890, son of the late Dr. William J. and Mary Coyle; was educated in the local schools, and graduated from St. Bonaventure's College in 1911. He received his degree in medicine from Georgetown University in 1918; interned at the Georgetown University Hospital in Washington, D. C., and afterward at St. Vincent's Hospital in Bridgeport. His professional career was started in Bridgeport, but he relocated in Windsor Locks in 1928 upon the death

of his father. Here also practiced a sister, Dr. Anna Coyle.

He was a member of the American Medical Association, Connecticut State Medical Society, the Bridgeport Medical Society, and the Riverside Council, K. of C.

Besides his widow, Mrs. Mary E. (Rapp) Coyle of Windsor Locks, Dr. Coyle leaves one sister, Mrs. Loretta McGrath of South Windsor, and several nephews.

During recent years, Dr. Coyle's participation in active practice had been hindered by worsening eyesight, but his passing notably rounded out nearly one hundred years in the medical profession by this man, his sister Anna, and his father.

John J. Kennedy, Jr., M.D.

Gustav Wilens, M.D.

1897 - 1954

Gustav Wilens was born in Hartford, Connecticut, December 14, 1897. He attended public schools in Hartford and entered Wesleyan University in 1917 where he stayed for one year. In 1918 he transferred to Yale and received his PH.B. there in June, 1920. He was entered in a combined course at Yale University and received his M.D. from Yale in 1923. Dr. Wilens was for a short time instructor of pathology at Harvard Medical School and was an intern at Peter Bent Brigham and Children's Hospitals in Boston, Massachusetts. Upon completing his hospital service, he entered the practice of pediatrics in Utica, New York in 1928 where he remained until 1934 when he removed to Connecticut and engaged in the practice of pediatrics in Torrington. Dr. Wilens became a member of the Litchfield County Medical Association and the Connecticut State Medical Society, but was dropped from membership after a few years, and then moved to Massachusetts.

On December 9, 1944 he married Catherine Irene Williams at her family home in Westfield, New Jersey. They returned to Connecticut in 1953 and settled in Danielson. That same year he again became a member of the Connecticut State Medical Society through the Windham County Medical Association, and continued in good standing until his death on November 19, 1954.

"Gus," as he was known to his friends, was an ardent sportsman, being a follower of Izaak Walton in the gentle art of angling, although, unlike Walton, he preferred the artificial lure and was expert

at tying his own flies. His love of dogs led him, upon his retirement from active practice because of health, to the breeding of pointers and cocker spaniels with some success. He loved guns, hunting and target shooting. And as if these activities were not enough to satisfy his restless energies, he had also become an amateur tool maker, and spent many productive hours in his machine shop.

At his death Dr. Wilens was a member of the Hezekiah Bearsley Pediatric Club, and the New England Pediatrician Society, and was a Diplomate of the American Board of Pediatrics. He is survived by his wife, his mother, two sisters and one brother, and one daughter, Paula, by a former marriage. Burial was at Cedar Hill Cemetery, Hartford, Connecticut.

John A. Woodworth, M.D.

Francis Joseph Aldwin, M.D.

1906 - 1955

Col. Francis Joseph Aldwin (Ret.) MC-USAF, died on October 8, 1955 at the Veterans Administration Hospital, West Haven, after a month's illness.

Dr. Aldwin was born in Meriden on March 30, 1906, the son of Egnacy Awdzienicz. He attended the Meriden High School, received the Bachelor of Science Degree from Yale University in 1929 and M.D. degree from the Yale University School of Medicine in June, 1932. In 1932-33 Dr. Aldwin was an intern in the Massachusetts General Hospital and in 1933-34 was on the house staff of the Massachusetts Memorial Hospital. He was licensed to practice in Connecticut in July, 1934 and soon thereafter entered the private practice of medicine in Stamford where he continued until 1941, when he entered military service, was a First Lieutenant, MC, assigned to the 192nd Field Artillery. He became a member of the Fairfield County Medical Association in 1937. At the end of World War II Dr. Aldwin elected to remain in the Medical Corps and continued until his retirement in 1955, serving in several posts, his last assignment being at Guntner Air Force Base, Montgomery, Alabama and maintained a home address at 185 Crown Street, Meriden.

Dr. Aldwin married Anne Frances Tutak, who survives him and there are four children, Francis Joseph Aldwin, Jr., Lois Ann, Mary Elizabeth and Carolyn.

Col. Aldwin was buried in the Arlington National Cemetery in Virginia.

Creighton Barker, M.D.

ARE YOU TAX BAIT?

RALPH R. BENSON, LL.B., *Los Angeles, California*

The Author. *Attorney at Law*

This is the second in a series of articles designed to help the physician to be more meticulous in his bookkeeping and thus less apt to encounter difficulties with federal revenue agents.

BAIT No. 3

ARE YOU CLAIMING DEPENDENTS OTHER THAN YOUR WIFE AND CHILDREN?

Dr. C became a tragic victim of an automobile vs. train accident which claimed the lives of his wife, his wife's father and uncle. His wife had been driving the car. She had just picked up her family at the railroad station. They had come for a short visit. Dr. C immediately became the sole support of his injured mother-in-law who survived the wreck after sustaining a fractured femur. He also became the sole support of the injured first cousin of his wife who was 22, unmarried, a schoolteacher, who had also been in the wreck. The cousin had sustained a brain lesion and required care in a sanitarium. Although the Coroner's inquest showed his wife was not at fault at all, the doctor feels morally obligated to support the two survivors, the mother-in-law and this unfortunate young lady cousin, to the fullest extent.

In a strict legal sense, the mother-in-law and cousin-schoolteacher are now unrelated to the doctor. His wife, when she was living, was the legal link between her family and the doctor. These legal distinctions, however, did not prevent the doctor from contributing far more than one-half the total support of these two. On his tax return he claimed these two for the first time this year, entering their names in the newly added box for relatives on page 2, claiming \$1,200 for them as well as \$600 for himself and as well as another \$600 for his mother-in-law who was over 65. This tax return will be red pencilled by the local tax office and thoroughly checked. Any dependents outside of a wife and child will now stick out like a sore thumb because of the new tax form and, besides, the doctor was making a new tax law when he claimed a presently unallowable \$600 for his mother-in-law just because

she was over 65. This over 65 extra allowance can only be claimed by a taxpayer's wife or husband and not for any other relative. Or, if the mother-in-law had her own income and filed her own return, she could have claimed the extra \$600 for herself.

As to the mother-in-law, the doctor would be allowed the basic \$600 even though she is now unrelated. The tax people consider the relationship as still going on whether she lived with the doctor before the accident or not. As to the school teacher in the sanitarium, the doctor would not be allowed one cent of dependency exemption because the cousin did not reside with the doctor before the accident. The cousin's exemption will be red pencilled, the doctor will be called into the tax office and told why. The tax law about dependents is that complicated and inconsistent.

The moral is: Dr. C now sees a lawyer or an accountant rather than going to the news stand for any of the popular "simplified" one hour tax courses. A tax advisor would have filled out the form correctly and would have attached to the return for the first year a simple explanation that the proper relative was claimed and this whole problem of the red pencil and personal tax lecture would have been avoided. This personal note attached to the return by the accountant is effective and humanizes it. It saves the Government unnecessary checking and minimizes the ever present memories of the tragedy. Besides, a tax advisor would tell the doctor he is entitled to another \$600 exemption legally allowable for his wife, although she passed away before December 31. He is also entitled to file a joint return and pay his taxes on a split income for that year.

BAIT No. 4

IS YOUR INCOME OVER \$20,000 A YEAR?

Dr. D earned a net income of \$27,000 this year for the first time. When he sat down to make out his own tax return, he was very careful to describe his first venture this last year into the rising stock market. He had purchased shares of a supposedly high grade growth company which proved slightly

undesirable since it had a tendency to shrink. This he had purchased on the tip of an obscure radio reporter on a local station. He kept this stock three months. It went down five points so he dumped it. He entered on his tax return a short-term capital loss. Sufficiently soured by this bitter experience, he even sold shares in a company he had been given by his mother years ago for a small, long-term, capital gain. This old stock in a small private company had not paid dividends for the past twenty years. The doctor had received \$35 in dividends on that single stock purchase he had made this year. He entered \$35 in Schedule J on his and his wife's joint return, but found it rough going trying to fill out the rest of the required dividend credit or exclusion questions. After trying for one-half hour to figure out the instructions in the tax pamphlet furnished by the Government, he decided to cross out everything about the \$35 dividends, leaving it blank, because he figured somehow that the dividends, being so small, under \$50, would be excluded anyway from his taxable income. He was right on that, but wrong not to fill it out. His return as filed showed accurately the stock transactions and his \$27,000 net, and nothing about dividends received or dividend credits claimed. The local tax office flagged his return because his income was over \$20,000 and because it seemed suspicious to the first tax checker that the doctor did not report any dividends when the doctor apparently had owned and sold stocks in two companies. The tax checker at his desk at the Federal Building pulled down the latest copy of Moody's Stock Service and confirmed the low stock dividend on the listed securities purchased this year, but could find no listing on the older private company or the size of any dividends distributed to the stockholders. An ounce of suspicion thus created tipped the scales of this taxpayer in the over \$20,000 a year category for a tax checkup.

The moral is: Every return over \$20,000 net income is carefully reviewed at the tax office. The slightest suspicion of something wrong will bring the tax man to the taxpayer for a tax talk. Had Dr. D consulted a lawyer or accountant to fill out the dividends received portion, he still would have paid no tax on the \$35 and it would have given the doctor another tax deduction for money paid to the lawyer or accountant. And probably saved himself the visit from the tax investigators.

BAIT No. 5

IS YOUR RETURN PART OF A "SPOT" CHECK?

Take the case of Dr. E. Last year his return was investigated for 5 days and was found correct to the last penny—after 3 investigators had gone through his daily log entries and some 4,000 medical charts.

This year again the tax man is at his office to go through his latest return and his books. The doctor's face turns pale and he feels weak at the knees. He is honest—and harrassed—and feels that lightning has just struck twice. He wonders how come another checkup—was not last year's O.K. good enough for at least another year?

The tax man quietly offers a simple explanation: This year Dr. E's return had come up as part of a spot check completely unconnected with last year's investigation. This spot check is a scientific sampling of returns made every year by the Government. Call it the doctor's luck—just like a lottery.

Again we have something the doctor could not avoid—stemming from the mere fact that Dr. E's return was filed.

The moral is: Even though you were hit last year, don't drop your guard. Always keep your books in A-1 shape. Last year's clearance is no guarantee against the possibility of reinvestigation this year.

BAIT No. 6

HAS YOUR PATIENT BEEN CALLED IN TO PROVE UP
MEDICAL EXPENSES ON HIS OWN RETURN?

Dr. F is a GP and three winters back made many house calls out in the country for a patient and his family. He gave shots of bicillin and penicillin, charged \$10 each time and was paid in cash. Dr. F marked down the payment in his daily log book on getting back to his office. As in many unwary doctor's offices, his assistant made out a receipt leaving the carbon copy in the receipt book and quickly crumbling the original and assigning it to the waste paper basket. It never entered the doctor's mind to have his girl put the receipt in an envelope and mail it to the patient. It did not occur to him that he might be leaving himself wide open for future tax investigation of his own return.

This patient filed a tax return for that year three years ago, listing \$400 expenses from Dr. F. The patient was called in to prove up this amount. He confirmed the first \$100 by producing the cancelled checks for office visits but as to \$300 claimed for house calls, the patient had no cancelled checks and

no receipts. The tax man told the patient to get a letter from the doctor and have the doctor's signature notarized to prove the \$300 paid in cash. The doctor looked at his receipt book and could not remember three years back and found only carbon copies of receipts totaling only \$30. The patient insisted on the full \$300. The patient may well lose \$270 of medical deductions and the doctor may find himself on a list for a scheduled tax examination of his own return at his office.

The moral is: Dr. F now sends receipts on all house calls. This is the ideal way to handle cash payments on all house calls, even if not the most common practice today. From a public relations view, it is a good idea to send a receipt. The receipt might well say: "Keep this receipt for tax purposes." After all, many charitable foundations and stock brokerage houses print that advice on their receipts. Why shouldn't the doctor protect his patient and himself by this simple method?

BAIT No. 7

HAS AN INFORMER TOLD A STORY ABOUT YOU?

Dr. G is an internist in a city of 10,000 population. Uranium is discovered nearby and the city swells to 20,000 almost overnight. The doctor's caseload per day had been 10; with the boom his caseload jumps to 40. He is busy to the point of distraction. He places an ad in the paper for an assistant and hires the only applicant who calls. No investigation is made of her background or references. She is to be a combined housekeeper, receptionist and technician. After a month's trial, the doctor finds his records and charts in a mess, which were bad to begin with, and had not been improved by her. He discharges her although he is unable to replace her. Each day his records continue to grow worse. The pressure of the practice is beating him to a pulp. This ex-assistant, in her hurt pride and bitterness, sends an anonymous letter to the Internal Revenue Service, stating: in her opinion, the doctor was failing to report his total income on his tax return. Although she acted with malice and without evidence, she turned out to be right in that the doctor had not reported his full income. Dr. G. is honest and she knows it.

Acting on this anonymous tip, the IRS makes an investigation of the doctor's latest return. As a result, an actual underpayment of taxes is uncovered and an assessment made against the doctor in the sum of \$10,000 additional tax due, plus 6 per cent interest from the day last year's return was due, after going through the doctor's hodge-podge of so-called records. But the Government has also sent him the second part of the bill for another \$5,000 as a fraud penalty computed on 50 per cent of the first part of the bill. The doctor feels he has done no intentional misdeed. The Government insists upon the fraud penalty because they feel that Dr. G had wilfully intended to evade a tax, by failing to unscramble his books when he should have known that his tax return, which he sent in, could not report his true income when his books were as bad or worse than no books at all. At best, Dr. G certainly does not show up in a favorable light.

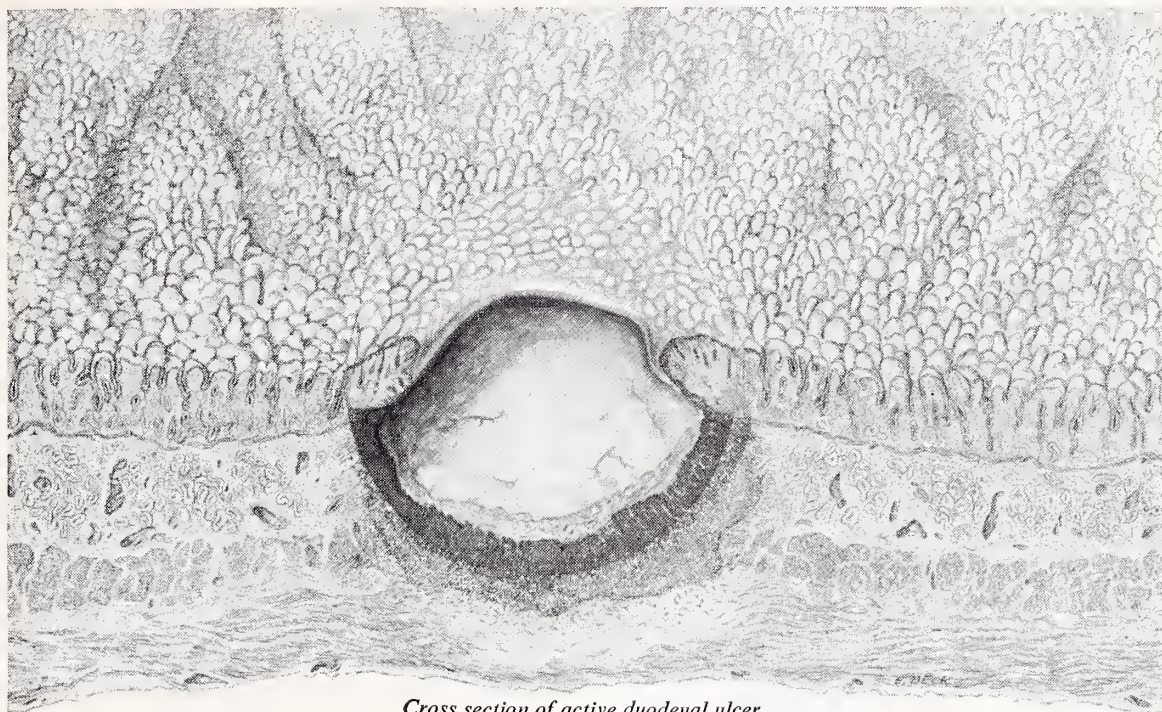
Dr. G, being all worked up, appeals this fraud penalty to the United States Tax Court. The doctor is losing time from his practice and footing a steep bill from his attorneys and accountants. Top it off, the local newspaper carries the story of his tax troubles and his patients gossip about it. The Tax Court upholds the findings of fraud. Again, the doctor still feels he is right and doggedly appeals the matter to an even higher court, the Circuit Court of Appeals. He is lucky if his blood pressure does not go up too. The Circuit Court of Appeals rules in his favor, deciding that a doctor who is busy to the point of distraction and could not obtain help to properly perform his services and maintain his records, could not be guilty of fraud. The Court cancels this bill for \$5,000 of fraud penalty but the doctor has actually paid more in fighting the case in trying to save his conscience and his reputation.

Had the Government tried to prove negligence, which carries only a 5 per cent to 25 per cent penalty, they might have been able to make it stick more easily than the charge of fraud.

The moral is: Keep your books in a messy state and you give informers a field day.

(To be continued)

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1. Ruffin, J. M.; Baylin, G. J.; Legerton, C. W., Jr., and Texter, E. C., Jr.: Mechanism of Pain in Peptic Ulcer, *Gastroenterology* 23:252 (Feb.) 1953.

2. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: A Clinical Evaluation of a New Anticholinergic Drug, Pro-Banthine, *Gastroenterology* 25:416 (Nov.) 1953.

SEARLE

SPECIAL NOTICES

NATIONAL BOARD EXAMINATION SCHEDULE FOR 1956

Part II only — April 24, 25

Parts I and II — June 19, 20

Part I only — September 4, 5

Candidates may file applications with the central office at any time, except for the Part III examinations. However, applications must be received at least six weeks in advance of a specific examination date.

New candidates should apply by formal registration with the National Board. This consists of submitting a completed application blank and affidavit of identification. Registration material is supplied by the Philadelphia office, or may be obtained through the office of the dean of the medical school. Copies of the Bulletin of Information containing rules and regulations governing National Board examinations are also made available to new candidates.

In all correspondence applying for examinations, candidates are requested to refer to candidate number and to write their names legibly. It should be kept in mind that examining centers for Parts I and II cannot be established until after close of registration. Where there is a minimum of five candidates, the examinations can be organized for that center, but it is necessary for all applications to be submitted before this can be determined.

Application for Part III examinations is made by formal registration for a specific examining center and application forms for this purpose are sent to eligible candidates after the dates have been set. Part III is administered through Subsidiary Boards located in the major cities of the United States during the last two weeks of June each year. Where indicated, interim Part III examinations will be organized by an individual Subsidiary Board during the course of the year, announcement of which will be published in *The Examiner*.

NEW OUTPATIENT CLINIC IN NEW HAVEN

Beginning November 1, 1955, the Connecticut State Hospital at Middletown is setting up an outpatient clinic in New Haven, which will serve the Greater New Haven area. The purpose of the clinic is to serve only those individuals still under the Connecticut State Hospital's responsibility. These are people, for example, who have been patients in the hospital, have left the hospital and have returned to the community on extended visit, but who have not actually been discharged from hospital responsibility. They are customarily discharged from extended visit, if their condition permits, one year from the date they leave the hospital.

The outpatient clinic will be operating on a part-time basis for the present and will be open every Tuesday only, from 8:30 A. M. to 4:30 P. M. It will be located at 171

Church Street in the City Hall Annex and will occupy the same space as the Preventive Medicine Clinic of the New Haven Health Department. The telephone number is LOcust 2-0151, Extension 365.

The clinic will be attempting to follow, on a casework basis, those individuals who may need help in reestablishing themselves in the community.

CONGRESS ON INDUSTRIAL HEALTH

Ways of keeping the American worker healthy and on-the-job will be considered by representatives of labor, management, government and the medical profession at the 16th annual Congress on Industrial Health Monday and Tuesday, January 23-24, at the Sheraton-Cadillac hotel, Detroit. Sponsored by the AMA's Council on Industrial Health, the sessions on Monday will be devoted to "The Role of Medicine in Industrial Relations" and "Medicine's Responsibilities in the Automotive Age."

A special all-day program on Tuesday will be built around the subject, "Absence from Work Due to Non-Occupational Illness and Injury," with particular reference to integration between industrial and private physicians. This program—arranged by the AMA's Committee on Medical Care for Industrial Workers—will cover such aspects as the nature and extent of the problem, efforts of management, labor and the community to reduce job absence, the role of various persons (for example, the worker, personnel director, nurse, doctor) in this field, and a discussion of the Ontario System of recording absence data.

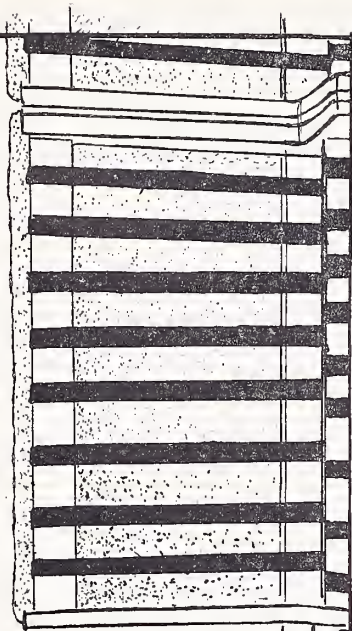
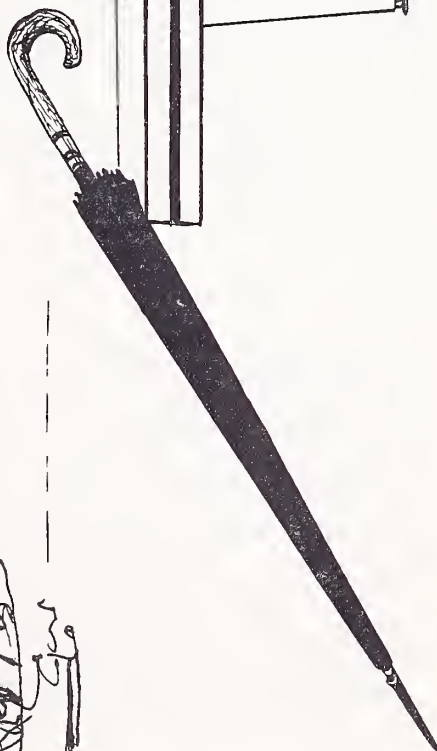
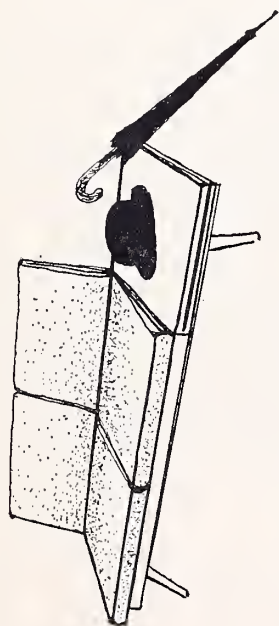
PAN AMERICAN CONGRESS ON OPHTHALMOLOGY

When the 5th Pan American Congress of Ophthalmology meets in Santiago, Chile, January 9-14, 1956, the following subjects will be discussed by panels of physicians from North, Central and South America: glaucoma, collagen diseases, infantile glaucoma, secondary glaucoma, strabismus, detachment of the retina, psychosomatic ophthalmology, tropical diseases of the eye, physiopathology and surgery of the crystalline lens, plastic surgery, visual fields and neuro-ophthalmology, and intraocular tumors. Papers will be presented in Spanish, Portuguese, and English, with simultaneous translations.

The congress will include a scientific exhibit, a display of ophthalmologic literature, and a program of scientific films related to diseases of the eye. Ophthalmologists who desire further information about the program may consult Dr. James H. Allen, 1430 Tulane Avenue, New Orleans, La. Inquiries about other phases of the congress may be addressed to the acting secretary for countries north of Panama, Dr. Daniel Snyder, 109 N. Wabash Avenue, Chicago 2, Ill.

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RADIOLOGICAL SOCIETY OF NORTH AMERICA

Meets in Chicago, December 10-16, 1955.

AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE

Meets in Atlanta, Georgia, December 26-31, 1955.

AMERICAN PSYCHIATRIC ASSOCIATION

Meets in Atlanta, Georgia, December 27-28, 1955.

Expansion of Medical Education

The recent opening of the Albert Einstein College of Medicine in the Bronx marks the first time in almost sixty years that a new medical school has been founded in New York State. In 1954 the University of California at Los Angeles graduated its first class. In June, 1956 the University of Maine will graduate its first class. The University of Mississippi has completed a \$9 million construction plan and will admit its first third year class in June. The University of Missouri is converting from a two year science to a four year medical college. The University of Florida will admit its first medical class in June, 1956. Seton Hall College of Medicine in Jersey City will open in the autumn of 1956 according to present plans.

All this should help alleviate to some degree the requirements of an expanding population and an

expanding military, as well as the development of new medical and health practice. The last annual report of the AMA Council on Education and Hospitals shows a drastic drop in numbers of applicants for admission to medical schools.

OUR NEIGHBORS

Massachusetts

The Boston Committee on Alcoholism has organized a new Professional Association on Alcoholism set up on a national scale and open to physicians, nurses, members of hospital administrative staffs, enforcement, correctional and penal officials, occupational therapists, social workers, research workers, counselors and others active in the treatment, prevention and rehabilitation program in the field of alcoholism.

The new president is James I. Roberts, medical director of the New England Electric System and New England Counselor with the Industrial Medical Association. Since membership in the new organization is not confined to Boston or New England, all inquiries concerning membership and programs of the new association will be welcomed by the secretary-treasurer, David Landau, medical director of the Boston Committee on Alcoholism, 419 Boylston Street, Boston.

Advertisers in our journal are carefully selected. Only those meeting our advertising standards may use the facilities of our pages. No advertisement will be accepted which, either by intent or inference, would result in misleading the reader. May we suggest that you review the ads in each issue of our journal and, when occasion arises to prescribe products featured or use the facilities offered, tell them you saw their ad in the Connecticut State Medical Journal.

NEWS

from County Associations

Hartford

Twenty-one living past presidents were honored in October at the 163rd semi-annual meeting of HCMA at the Hartford Club, Thomas M. Feeney, president, reported. This was the first time in the Association's recorded history that recognition was given to any presidents for their services during the years.

Oldest living past president is John Law Bridge of Hazardville who is ninety-six this month. He was president in 1919. Other past presidents honored are: Henry Costello, William Upson, James R. Miller, C. Brewster Brainard, Arthur Brackett, Albert R. Keith, Arthur B. Landry, Ralph A. Richardson, Maurice T. Root, Edward J. Whalen, Thacher W. Worthen. Others are: William R. Hanrahan, Edward A. Deming, Louis P. Hastings, Charles Schechtman, Ralph Ogden, James R. Cullen, Amos E. Friend, Burdette J. Buck, and Orin R. Witter.

The first honorary membership award of the association was given to Dr. John F. Enders, Harvard Medical School bacteriologist and Nobel Prize winner, for his polio tissue culture work. The evening program then ended with professional entertainment.

Lane Giddings, former vice-chairman of the Manchester Red Cross, was named chairman at the annual meeting of the organization this month. Dr. Gidding is pathologist at the Manchester Memorial Hospital and began his duties there in 1952. He is a graduate of the University of Massachusetts and Hahnemann Medical College.

Drs. John Beakey, Ludwig Frank, Myron Freedman, Wilson Fitch Smith and Robert Molloy are all lecturers in the Hartford High School Adult Evening program called "The Doctor Talks it Over." This program is jointly sponsored by HCMA and the Greater Hartford Tuberculosis and Public Health Society.

Last month Louis Hastings, St. Francis Hospital pathologist, appeared on WKNB-TV in a program called "At Your Service." This program concerned the importance of giving blood.

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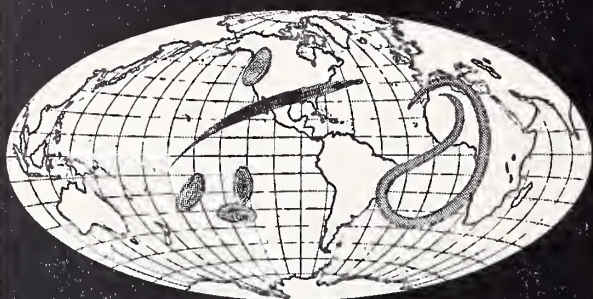
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chester pediatricians have conducted a study of injuries among children. This study is being sent to the State chairman of the American Academy of Pediatrics.

Freeman P. Clason's son Walton has recently been admitted to student membership in the Connecticut State Medical Society. He is a graduate of Harvard Medical School and is now interning at Hartford Hospital.

Up to October 15 HCMA's drive to raise funds for the American Medical Education Foundation has resulted in collecting only \$1,543, it was reported by Charles E. Jacobson, Jr., county chairman.

He said that many physicians have indicated that they have made their contributions directly to their medical schools. Dr. Jacobson pointed out that the annual deficit of ten million dollars of the country's 80 medical schools is over and above the funds contributed by physicians directly to their medical schools, and, in fact, is the very reason for the creating of another source of income for the medical schools.

He said, "While there is confusion when an appeal for one cause is received from two different sources, the way to resolve this difficulty is to make your contribution to AMEF and earmark it for your medical school. In this way confusion is avoided, and acknowledgment of the contribution is received both from AMEF and the medical school."

In Hartford County the local committee working in conjunction with national AMEF headquarters and the State Medical Society has set a goal of \$9,000 for 1955. Serving on the local association committee along with Dr. Jacobson are: Henry Pollock of Bristol, Walter Kosar of Hartford, and Andrew Canzonetti of New Britain.

Last year's statistics show that Connecticut doctors contributed \$12,862 to AMEF with 381 donors. However, 1,026 physicians contributed directly to their alumni fund to the tune of \$26,485.16, making a total of \$39,347.66 given to the country's medical schools. This placed Connecticut eleventh in the country in terms of dollars volume and ninth in number of donors. Dr. Jacobson pointed out that any funds collected in the county will be specifically earmarked for the donor's medical school unless he indicates otherwise.

Wilmar M. Allen, former director of the Hartford Hospital, has moved to Chapel Hill, North Carolina where he will be engaged in a consultative capacity.

The new officers of the Hartford Hospital medical and surgical staff are Philip G. McLellan, presi-

dent; G. Gardiner Russell, vice-president; and Louis F. Middlebrook, secretary.

Robert Barry, Charles Bingham, Francis J. Braceland and John C. Allen were the lecturers at the seminar for the clergy conducted at the Hartford Hospital in November.

Ralph M. Tovell, chief of the department of anesthesiology at the Hartford Hospital, was elected president of the Academy of Anesthesiology which met in Hartford recently. This was the first session of the Academy since its formation one year ago.

Hugh J. Caven of Hartford, a member of the editorial Board of the JOURNAL, attended the State Medical Journal Conference recently held at AMA headquarters in Chicago.

DR. BRACELAND NAMED TO MENTAL COMMISSION

Dr. Francis J. Braceland, psychiatrist-in-chief of the Institute of Living, has been named a representative of the newly formed national Joint Commission on Mental Illness and Health, Inc.

The announcement was made recently by Dr. Leo H. Bartemeier, chairman of the Commission's board of trustees. The group comprises representatives of leading national organizations and agencies with primary interests in mental health.

The Commission was formed in September for the express purpose of carrying out the Mental Health Study Act of 1955. The act authorizes the Surgeon General of the U. S. Public Health Service to grant funds to a nongovernmental organization to make a three-year nationwide study of the human and economic problems of mental illness.

Dr. Braceland will serve under Dr. Kenneth E. Appel, professor of psychiatry at the University of Pennsylvania School of Medicine, president of the commission.

* * * *

Norman J. Barker of Hartford, medical director of the Connecticut General Life Insurance Company, has been elected vice-president of the Association of Life Insurance Medical Directors of America and J. Grant Irving of Hartford, medical director of the Aetna Life Insurance Company, has been elected treasurer of the same organization.

Two other Hartford medical directors were named to the Association's Board of Life Insurance Medicine. They are D. Sergeant Pepper, associate medical director of the Connecticut Mutual Life Insurance Company, and Archibald C. Wilson, medical director, reinsurance of the Connecticut General Life Insurance Co.

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Bumbalo, T. S., Gustina, F. J.,
and Oléksiak, R. E.:
J. Pediat. 44:386, 1954.

White, R. H. R., and
Standen, O. D.:
Brit. M. J. 2:755, 1953.

against ROUNDWORMS

"Ninety per cent of the children passed all of their ascarides . . ."

Brown, H. W.:
J. Pediat. 45:419, 1954.

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On October 23 the people of Unionville paid tribute Edward P. Dunne, general practitioner in that town for the past 38 years. There was a parade, reception, and testimonial dinner. Among other tangible tokens Dr. and Mrs. Dunne received a new automobile, and the doctor was given a shotgun and made an honorary member of the Farmington Game Club. More than 2,000 townspeople turned out for the celebration.

Litchfield

The New Milford Hospital Board of Trustees has announced the following officers of its medical and surgical staff: George Le Taif, chairman; John Simmonds, vice-chairman; and Margaret Stanley-Brown, secretary.

Robert Hazen, Thomaston's oldest physician, died at his home on November 1 after a long illness. As well as practising medicine in Thomaston since 1902, Dr. Hazen had been very active in town affairs.

Middlesex

One of the most enjoyable semi annual county association meetings this year was the one held by the Middlesex County Medical Association at Restland Farm in Northford. The reason for this statement is the fact that the meeting was graced by the presence of the County Woman's Auxiliary who were invited guests of their husbands.

Dr. Stringfield, president, and Dr. Barker, secretary of the State Society were present, together

with Dr. Wallace, director of the Connecticut Regional Blood Program, Dr. Horton, medical director of CMS, and Dr. Weld, editor of the JOURNAL.

Rev. Edmund Opitz from the Foundation for Economic Education, Inc., as after dinner speaker gave a very erudite addresss on the philosophy of the Foundation. At this meeting two men were elected to membership: Charles W. Chace, who is in general practice in Middletown, and Franz Hasselbacher, who is clinical director at the Connecticut State Hospital.

Harold Smith of Middlefield has been appointed medical examiner for the town of Durham.

Richard Grant was at Mt. Sinai Hospital in New York for a week to take a full time course in electrocardiography.

"Parinaud's Sign" is the title of an article which appeared in the September issue of the *Hartford Hospital Bulletin*. Co-author was Arthur McDowell.

We were well represented in Chicago during the last few weeks. Clarence Harwood was there early in October to attend a meeting of the American Academy of Pediatrics. A week later Christie McLeod attended a meeting of the American Society of Clinical Pathologists. The same week Mark Thumim presented a paper at the annual meeting of the American Academy of Ophthalmology and Otolaryngology. Early in November Donald Arnault attended the Clinical Congress of the American College of Surgeons. At this meeting he was inducted as a Fellow.

New Haven

Jasper A. Smith of Waterbury participated in one of the workshops at the Third Annual Conference on Aging held at the University of Connecticut in November under the auspices of the Connecticut Society of Gerontology.

H. M. Marvin, literary editor of the JOURNAL, attended the 28th annual session of the American Heart Association held in New Orleans in October.

James A. Flagg has been appointed chief of anesthesiology at the Griffin Hospital, Derby, effective January 1, 1956. Dr. Flagg received his M.D. from Temple University School of Medicine in 1951 and on December 31, 1955 will have completed his residency in anesthesia at the Massachusetts General Hospital.

Edward M. Cohart, associate professor of public health, is on leave of absence to serve as deputy commissioner of health for the City of New York.

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This newly created position, which has been filled by Dr. Cohart, is for evaluation and planning. In May Dr. Cohart was chosen to be president-elect of the Connecticut Public Health Association.

New London

The monthly meeting of the New London County Medical Association was held November 3 at Uncas-On-Thames. The speaker was John Leonard, director of Medical Education at the Hartford Hospital, who spoke on "Anemia." The speaker was preceded by Mr. Howard Bierkan from CMS, who showed a movie entitled "Dear Doctor."

The regular monthly meeting of the staff of the William W. Backus Hospital was held November 10. Bernard Brody of New Haven spoke on "Subdural Hematomas and Cervical Disc Lesions."

The New London Chapter of the Connecticut Heart Association presented its monthly cardiovascular lecture November 10 at the Lawrence and Memorial Hospital, New London. The guest speaker was Maurice Bruger, associate professor of medicine at New York University Post Graduate School of Medicine. His subject was "Electrolyte Disturbance in Chronic Heart Failure." The program was under the direction of Dr. Joseph M. Wool, who is chairman of the medical program for the following year.

At the monthly dinner lecture meeting of the Lawrence and Memorial Hospital, held on October 20, 1955 the speaker was Harry Miller, surgeon at the New England Center Hospital and assistant professor in surgery at Tufts University Medical School. His subject was "Surgical Aspects of Hyperparathyroidism."

The St. Luke's Guild attended "White Mass" in honor of Saint Luke, Patron of Physicians, held on Sunday, October 16, at Saint Patrick's Cathedral, Norwich.

Windham

The 164th semi-annual meeting of the Windham County Medical Association was held at the Nathan Hale Hotel, Willimantic, Thursday, October 20. Following dinner and business meeting, E. B. Prout of Hartford gave a talk entitled, "Medical Aspects of the Flood." Among the guests were Oliver L. Stringfield, president of the State Medical Society and C. Louis Fincke, chairman of the Council.

Edward J. Ottenheimer of Willimantic was recently elected president of The American Cancer Society, Connecticut Division.

News from Yale University School of Medicine

Dr. Herbert M. Edwards, noted authority in tuberculosis work has been appointed associate professor of Medicine and Public Health at Yale University. The appointment is effective immediately. Dr. Edwards comes to Yale from New York City where he has been executive director of the New York Tuberculosis and Health Association since 1947. He has been named to a newly created post at the Yale School of Medicine. His responsibilities include teaching, research and consultation with special emphasis on tuberculosis control work, not only at the Yale-New Haven Medical Center but also in the New Haven area.

In addition to his title as associate professor at Yale, Dr. Edwards will be consultant on tuberculosis at the Grace-New Haven Community Hospital. In this work he will help in the further development of a New Haven area TB control program, with the cooperation of the New Haven Area Tuberculosis and Health Association, various public health nursing agencies, TB sanatoria, and the several city and town health departments in the area.

Dr. Edwards also will direct a William Wirt Winchester Clinic in Grace-New Haven Hospital, and will help develop cooperative and coordinated plans among the health and welfare agencies in relation to TB control work.

NEW BOOKS IN REVIEW

RESERPINE IN THE TREATMENT OF NEUROPSYCHIATRIC, NEUROLOGICAL AND RELATED CLINICAL PROBLEMS. Published in the *Annals of the New York Academy of Sciences*. Volume 61, Article 1. Pp. 1 to 280.

Reviewed by WILLIAM W. ZELLER

This is a collection of papers presented in February, 1955 before the New York Academy of Sciences at a symposium on Reserpine. Six of the papers were concerned with reporting present-day knowledge of the neurophysiology of Reserpine. Twelve papers described the clinical usefulness of Reserpine in treating psychotic patients in public hospitals. The remaining ten papers reported clinical experience of private practitioners of psychiatry, pediatricians, neurologists, neurosurgeons, internists, and dermatologists with the use of Reserpine.

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Doctor retiring after successful career. He is selling both his practice and his excellent six room brick home in West Hartford. He has one office in his home with full bath on first floor. Two bedrooms on second with lavatory and full shower. Double brick garage. He also has an office in Hartford. Write: Murphy Realty Co., 1133 Farmington Avenue, West Hartford, Conn., or call ADams 3-4220.

BOOK REVIEWS—Continued

The neurophysiology of Reserpine is not yet clearly understood. Bein believes that the drug activates inhibiting, central substrates located mainly rostral to the caudal colliculi; Reserpine is assumed to act upon central, regulatory mechanisms which integrate autonomic and somatic functions. Schneider *et al* state that, although the main effects of Reserpine seem to be restricted to autonomic functions, apparently other parts of the central nervous system are affected. The clinical observation of parkinsonian symptoms and convulsions certainly indicate that other than central autonomic effects can be obtained after clinical doses of Reserpine. Rinaldi and Himwich showed that Reserpine has a stimulating effect on the reticular formation in the brain stem, which tends to explain why patients can be aroused easily from their state of tranquilization. The presence of cerebral cortex is necessary to produce the characteristic effect of Reserpine in cats. Schneider also showed clear-cut facilitation of the knee jerk in cats after Reserpine, and reasoned that the inhibition of afferent impulses would be caused by the facilitation of inhibiting cortical influences. The demonstration of a facilitatory action of Reserpine on synaptic transmission suggested a new aspect to the mode of action of the drug. Weiskrantz and Wilson, working with monkeys, found similarities in behavior between amygdaloidectomized animals and Reser-

pine-treated animals. They also found some differences and thus ruled out the amygdaloid region as a critical site of action of Reserpine. Rather, they believed the important area to consist of the prepyriform cortex, anterior insula, anterior temporal pole, and posterior orbital frontal areas in addition to the amygdala.

The experience of investigators from public hospitals with Reserpine was enthusiastically and optimistically reported. There was concurrence that in adequate doses ranging from 2 mgs. to 20 mgs. daily Reserpine, if used for at least three months, was able to control disturbed, agitated, and destructive psychotic behavior in patients, regardless of the underlying cause. The need for electroconvulsive treatment, insulin coma treatment, and lobotomy was reduced greatly in some institutions. Some chronic schizophrenic patients showed sufficient behavioral improvement as to be discharged from the hospital. Discharge rates were often used as criteria of drug effect. Little mention was made of follow-up studies or whether or not medication was continued after patients were discharged from the hospitals. The incidence of toxic reactions of Reserpine was low but many unpleasant side reactions were observed. Most investigators agreed that treatment should be pressed despite the occurrence of side reactions. Even the occurrence of parkinsonism, which can be treated symptomatically by antiparkinson drugs, is no contraindication to the continued use of Reserpine. Often side effects can be reduced by lowering the dose rather than discontinuing the medication. Kline cautioned against discontinuing the drug upon the appearance of the "turbulent phase," which is normally expected to occur about the second to third week of treatment. During this phase the patient's psychotic symptoms become aggravated. The turbulent phase is usually followed by a resolution of psychotic symptoms.

In the third group of papers, Drake and Ebaugh reported their experience in treating a small group of 40 private, psychiatric office patients. No sweeping conclusions could be drawn from their study, but they did believe that Reserpine was a valuable adjunct to psychotherapy particularly in anxiety tension states. Depressed patients did not improve. Other investigators reported cases in which Reserpine was effective in controlling restlessness associated with organic convulsive states, head injuries, narcotic withdrawal, pruritic dermatitides, asthma, and functional vascular headaches. Reserpine was found to be an effective tranquilizer in irritable and hypertonic infants, and in enuretic children. Reserpine administered preoperatively and postoperatively to surgical patients does not contribute substantially to the management of anesthesia or to the postoperative care of the patients. For this latter purpose, Chlorpromazine is the drug of choice.

THE 1955-56 YEAR BOOK OF MEDICINE. Chicago: Year Book Publishers, Inc. 1955. 711 pp. \$6.

Reviewed by DOUGLAS RUFANO

We are living in a compulsively scientific age. Each month voluminous literature from the highly theoretical to the frankly practical is thrust upon the medical profession. Thus

the physician is expected to keep abreast of new developments. The tremendous demands made upon the physician by his daily practice renders it a Herculean task for him also to peruse the literature wisely and adequately. For this reason, abstracts and digests serve a useful need in supplementing the one or two journals he is able to cope with; thus the value of the *Year Book*.

It is composed of six sections which are entitled: Infections, The Chest, Blood and Blood-Forming Organs, The Heart, The Blood Vessels and The Kidney, The Digestive System, and the Metabolism. Articles published from May, 1953 to May, 1954 were abstracted and inserted in the proper sections. The editors include such well known medical figures as Carl Muschenheim, Paul B. Beeson, William Castle, Tinsley R. Harrison, Franz J. Ingelfinger, and Philip Bondy. Each one covers the literature of his respective specialty. The table of contents is adequate and both subject and author indices are well detailed. The *Year Book* has 711 pages. Each abstract is approximately one to one and one half pages in length.

An interesting feature are the editor's notes. These follow many of the abstracts and help the reader evaluate the worth of the article. *The Year Book of Medicine* is an excellent work and can be quite helpful to the physician both in study and practice.

THE PEDIATRIC YEARS. By Louis Spekter, B.S., M.D., M.P.H., Director, Bureau of Maternal and Child Hygiene, Connecticut State Department of Health, formerly Chief, Division of Crippled Children, Clinical Instructor in Pediatrics School of Medicine, Yale University. Springfield, Illinois: Charles C. Thomas. 1955. 734 pp. Illustrations. \$4.

Reviewed by CREIGHTON BARKER

The broad spectrum of pediatrics is realized by the reader of this book. It covers almost everything in the field of medicine. The index starts with abortion and ends with yellow fever, neither of which are ordinarily thought of in connection with pediatrics, but there are many stops on the way between the two and the time spent is a rewarding experience.

It is an encyclopedic volume and its jacket calls it "a single source of information for all professional workers involved in the care of children." In this I would agree only in part. It should have a place in the library of every physician whose practice includes children but "all (other) professional workers" should be cautious that the book does not give them a sense of great and conclusive knowledge and not lose sight of the fact that they are accessories to the physician in caring for children.

Statements are made in a tersely, dogmatic style that leaves little room for disagreement and from the pen of a less careful author might be questioned, but from the hand of Dr. Spekter can be accepted as reliable.

For the mature pediatrician to sit and read of an evening before the fireplace, the book would turn out to be dull, but as a source of reference and consultation, it should be invaluable.

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